

FILED MAY 10 1945  
Registration District No. 1000

Primary Registration District No. 1000

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Sisters Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 days  
(Specify whether  
In this community Sera May Scheub  
years, months or days)

3. (a) PRINT FULL NAME Sera May Scheub

3. (b) If veteran, name war -  
3. (c) Social Security No. -

4. Sex F Color or race W  
6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife Charley Scheub  
6. (c) Age of husband or wife if alive 26 years  
7. Birth date of deceased 3-26-1878  
(Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days 9  
If less than one day hr. min.

9. Birthplace Andrew Co. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER  
12. Name Millard Reese  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Sophia Hatcher  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Charley Scheub  
(b) Address Rosendale mo  
17. (a) B. (b) Date thereof 5-9-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director L. C. Burt  
(b) Address Swamp mo  
19. (a) 5-8-45 (b) Walter J. Ginkle  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew  
(c) City or town near Rosendale  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 5  
year 1945 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from 5-1-45  
1945 to 5-5-45 1945  
that I last saw her alive on 5-5-45 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral embolism  
Duration 34 hr

Due to Operation for 4 day  
Due to Strangulated ventral hernia 18 yrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy 83 hr  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (e) Means of injury  
23. Signature Paul Ferguson (M. D.)  
Address 731 Garrison Date signed 5/8/45

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St. Joseph, Mo.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah Ga

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**