

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Evans
13447
State File No. _____
Registrar's No. _____

FILED APR 23 1945
129
Registration District No. _____

Primary Registration District No. 5467

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Rural Robberson Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Glidewell, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 43 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Robberson Township
(If outside city or town limits, write "RURAL")
(d) Street No. Glidewell, Mo.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Minnie Schutt

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 24 1848
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>96</u>	<u>1</u>	<u>18</u>	hr. _____ min.

9. Birthplace Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER {

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clara Correll

(b) Address Glidewell, Mo.

17. (a) Burial (b) Date thereof 4/14/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) Apr 14, 1945 (b) Mrs. Herman White
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12
year 1945 hour 4 minute a. M.

21. I hereby certify that I attended the deceased from April 5
1945 to April 12 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Infirmity of old age
Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature F. S. Evans (M. D. or other) _____

Address Springfield, Mo. Date signed Apr 14/45

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

1253

RECEIVED

Greene County Health Office,

County File Number 45440

Date Filed 4-20-48

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

Walter E Hamilton

Licensed Embalmer No.

3808

P. O. Address

Springfield, Mo.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may
Registrar's No. _____

Registration District No. 129 Primary Registration District No. 5467

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

1. PLACE OF DEATH:

(a) County Greene
 (b) City or town Rural Patterson Twp
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ years, months or days)

3. (a) PRINT FULL NAME Minnie Schult
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color W 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb. 2 1894
 (Month) (Day) (Year)

8. AGE: Years 96 Months _____ Days _____ If less than one day, _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name _____
 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) Mrs. Ferman White
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 1945 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN _____

Major findings:
 Of operations _____
 Of autopsy _____

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? _____
 While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

13447