DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 18 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

13764

State File No.

Registration District No. 110

Primary Registration District No. 3033

Registrar's No.

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

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial Hosp. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Days (Specify whether
In this community 2 Days years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Pulaski 85
(c) City or town Rural - Tavern TS. 0.
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Chas Schlicht
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male 0
5. Color or race
6. (a) Single, widowed, married, divorced Widower 9
6. (b) Name of husband or wife Lizzie Schlicht.
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Do Not Know (Month) (Day) (Year)

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) N.Y. 1 (State or foreign country)
10. Usual occupation FARMER.
11. Industry or business —
FATHER
12. Name John A. Schlicht
13. Birthplace (City, town, or county) Germany 1 (State or foreign country)
MOTHER
14. Maiden name Dont Know.
15. Birthplace " " (City, town, or county) 4 (State or foreign country)
16. (a) Informant Dr. Schlicht.
(b) Address Niangua, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 - 23 - 45 (Month) (Day) (Year)
(c) Place: burial or cremation Catholic Cem.
18. (a) Signature of funeral director J. L. Hoops + Sons
(b) Address Crocker, Mo.
19. (a) 3-27-45 (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 21 day March
year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 3/19, 1945, to 3/21, 1945, that I last saw him alive on 3/21, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	10 days
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature James L. Hope, (M. D. ~~or other~~)
Address Lebanon, Mo. Date signed 3/22/45.

1040

(Licensed Embalmer's Statement on Reverse Side)

Received .....
Laclede County Health Unit
File No. 3-45-28
Date Filed 4/17/45

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 Paul B. Hoop

Licensed Embalmer No. 3261

P. O. Address Waynesville 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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 110 Primary Registration District No. 3083 Registrar's No. 9

1. PLACE OF DEATH:

(a) County: Laclede

(b) City or town: Lebanon

(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME: Chas Schlicht

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years: 80 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country): N.Y.

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

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

19. (a) (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 21 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from, 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)	
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? (Specify type of place)
While at work? (e) Means of injury

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

SUPPLEMENTARY

13764