

No. 2
9-4-41
5-17-39
X2944

FILED JUL 14 1945

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 137

Primary Registration District No. 3028

Registrar's No. 123

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

1. PLACE OF DEATH:

(a) County Jasper Co.

(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: McCune Brooks 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether 1 day)

In this community Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence 55

(c) City or town Stotts City Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Cora Schnake

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15
year 1945 hour _____ minute 1:20 P. M.

21. I hereby certify that I attended the deceased from June 14
1945 to June 15, 1945
that I last saw him alive on June 13, 1945
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Henry C. Schnake

6. (c) Age of husband or wife if alive deceased years 26 1880
(Month) (Day) (Year)

7. Birth date of deceased Dec 26 1880
(Month) (Day) (Year)

Immediate cause of death Shock

Duration 2 1/2 hrs.

Due to Injuries in auto

Due to Forest - June 14-45

8. AGE: Years 64 Months 5 Days 11
If less than one day _____ hr. _____ min.

9. Birthplace _____ Illinois 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Harrison L. Cottingham

13. Birthplace _____ Kentucky 1
(City, town, or county) (State or foreign country)

14. Maiden name Martha J. Richardson

15. Birthplace _____ Illinois 1
(City, town, or county) (State or foreign country)

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

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Ed Schnake

(b) Address Mt. Vernon, Mo.

17. (a) Burial (b) Date thereof June 19-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cem. Stotts City

18. (a) Signature of funeral director N. D. Forrest

(b) Address Mt. Vernon, Mo.

19. (a) June 19 1945 (b) E. Elizabeth Cooper
(Date received local registrar) (Registrar's signature)

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 0

23. Signature Ed Schnake (M. D. or other) _____

Address Stotts City Mo Date signed 6-18-45

45-6-568

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.....

By me

....., Registered Apprentice No.

working under my personal supervision.

Signed..... *Max L. Fossett*

Licensed Embalmer No. *4252*

P. O. Address *W. Vernon, 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.

Registration District No. 157 Primary Registration District No. 3028

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Carthage
(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 Cora Schnake
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 Dec 26 (Month) (Day) (Year)

8. AGE: Years 64 Months _____ Days _____ If less than one day hr. _____ min. 26

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) _____ (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 June Day 15 Year 1945 hour 6:30 minute 14-45 M.
21. I hereby certify that I attended the deceased from June 16 to June 15, 1945
(that I have not heard him or her alive on _____ and that death occurred on the date and hour stated above.)
Immediate cause of death _____

Due to Causes of prostate
Due to Spock
Due to from automobile collision of another auto
Other condition _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____ Of autopsy _____
Duration _____
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) accident
(b) Date of occurrence June 14-45
(c) Where did injury occur? Lanana Co. Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Farm on highway
While at work? no (Specify time or place) (c) Means of injury _____

23. Signature W. J. Spock (M. D. or other) _____
Address Sanctuary Mo. Date signed 7-14-45

SUPPLEMENTAL INFORMATION REQUESTED

S-20627