

S. No. 2  
A-5-43  
5-17-39  
I X36871

**FILED JUL 18 1945**

Registration District No. \_\_\_\_\_

Primary Registration District No. **4020**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County **Madison**  
(b) City or town **Martinsburg**  
(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 **39** years, months or days

**3. (a) PRINT FULL NAME** **Charles Schaefer**

3. (b) If veteran, name war **L**  
3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male**  
5. Color or race **W.**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Elizabeth Schaefer**  
6. (c) Age of husband or wife if alive **67** years  
7. Birth date of deceased **Sept 17 1870**  
(Month) (Day) (Year)

8. AGE: Years **74** Months **9** Days **7**  
If less than one day \_\_\_\_\_ by \_\_\_\_\_ min.

9. Birthplace **Pennington, Ohio**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business \_\_\_\_\_

12. Name **Charles Schaefer**

13. Birthplace **Madison, Ohio**  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace **Madison, Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Charles Schaefer**

(b) Address **Madison, Ohio**

17. (a) Date there **Sept 27 1945**  
(Burial, cremation, or removal) (City or town) (County) (State)

(c) Place: burial or cremation **Burial, Martinsburg**

18. (a) Signature of funeral director **W. J. Ryland**  
(b) Address **Madison, Ohio**  
(Specify type of place) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

19. (a) **6/26/45** (b) **Marion Jacob**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State \_\_\_\_\_ (b) County **4**  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL") **0**  
(d) Street No. \_\_\_\_\_ (If rural, give location) **0**  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) **0**  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **June** day **23**  
year **1945** hour **3** minute \_\_\_\_\_ P.M.  
21. I hereby certify that I attended the deceased from **June 18** to **June 23**, 19**45**  
and that I last saw him alive on **June 23**, 19**45**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**  
Duration **5 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 \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(c) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature **W. J. Ryland** (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed **June 14 1945**

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 10  
District File Number 7-45-1187  
Date Filed JUL 17 1945

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 Self  
\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed A. B. Hall  
Licensed Embalmer No. 1588  
P. O. Address Hallsville Md

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. AugRegistration District No. 7Primary Registration District No. 4020

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County Audrain  
 (b) City or town Martinsburg  
 (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 Charles Schaper

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
- m

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

7. Birth date of deceased
- Sept 17
- 
- (Month) (Day) (Year)

8. AGE: Years
- 74
- Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day
- 
- hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation.....

11. Industry or business.....

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) (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)
- Mary C. Jacob
- 
- (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State
- MISSOURI
- (b) County
- AUDRAIN
- 
- (c) City or town
- MARTINSBURG
- 
- (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.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- Aug
- Day
- 23
- 
- year
- 1951
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19.....;

that I last saw him/her alive on \_\_\_\_\_, 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:

Of operations.....

Of autopsy.....

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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.....

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

SUPPLEMENTARY

S-23365