

S. No. 2  
M-2-43  
5-17-39  
X35697

**FILED** JUL 21 1945  
Registration District No. 209

Primary Registration District No. 3043

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

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: St. Elizabeth Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community entire life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

(c) City or town Hannibal  
(If outside city or town limits, write "RURAL.")

(d) Street No. 2912 Starfield  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Susan E. Schroder

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13  
year 1945 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from 6-10 1945 to 6-13 1945  
that I last saw her alive on 6-13 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, widowed

6. (b) Name of husband or wife David Schroder 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 20 1877  
(Month) (Day) (Year)

Immediate cause of death: Lt. hem. infarct due to cerebral hemorrhage

Due to Ch. arteriosclerosis + hypertension

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration 36 hrs

5 yrs

8. AGE: Years 68 Months 3 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation housewife

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

MOTHER FATHER { 12. Name Andrew J. Newlon

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

14. Maiden name Sarah Schultz

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

16. (a) Informant Mrs. B. W. Jamison

(b) Address 2912 Hubbard Hannibal Mo.

17. (a) Burial (b) Date thereof June 15, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Street Cemetery

18. (a) Signature of funeral director Ray P. Schwarz

(b) Address 1077 1/2 Hwy., Hannibal Mo.

19. (a) 6/19/45 (b) Dr. E. M. Lucke  
(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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Howard S. Schubert (M. D. or other \_\_\_\_\_)

Address Hannibal, Mo. Date signed 6-16-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

139K

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**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.....

*Jack H. Lueken*

Licensed Embalmer No.....

*4110*

P. O. Address.....

*Hannibal, 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.**