DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40630

FILED JAN 8 1946

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1357

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:
1401 Jules St.
(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 Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Buchanan

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

(d) Street No. 1230 No. 13th. St.
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Jacob E. Schmitz

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife (Unknown)

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

7. Birth date of deceased May (Month) 19 (Day) 1862 (Year)

8. AGE: Years 83 Months 6 Days 25 If less than one day ..... hr. ..... min.

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

10. Usual occupation Retired Butcher

11. Industry or business Own Business

MOTHER FATHER

12. Name Jacob Schmitz

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

14. Maiden name Marg Stubenhaber

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

16. (a) Informant Mrs. Catherine Shaffer

(b) Address Des Moines, Iowa.

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

(c) Place: burial or cremation Parnell, Missouri.

18. (a) Signature of funeral director Herman Wm. Schulenberg

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) Dec. 21, 1945 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 14 year 1945 hour 10 minute 50 A.M.

21. I hereby certify that I attended the deceased from 11/14/45 to 12/14 1945 that I last saw him alive on 12/13 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary congestion — Duration 24 hr.

Due to Chronic myocarditis — 1 yr.

Due to Fractured left femur — 4 mo.

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.

22. If death was due to external causes, fill in the following: 131

(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 [illegible] (M. D. or other)

Address [illegible] Date signed 1/4/45

(Licensed Embalmer's Statement on Reverse Side)

1428

ST. JOSEPH

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~~ Elmer Thomas, Registered Apprentice No. ..... working under my personal supervision.

Signed Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address St Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
45
43880

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

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State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1357

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(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)

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 Jacob E. Schmitz

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 md

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 19 (Day) 1862 (Year)

8. AGE: Years 83 Months 6 Days 25 If less than one day hr. min.

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

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) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month day
year hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary congestion	24 hr
Due to chronic impossibilities	1 yr
Due to fracture of left femur	4 mo

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 1860 18

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 8-12-45

(c) Where did injury occur? 1230 N. 13th (City or town) St. Joseph (County) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home — field.
(Specify type of place)

While at work? no (e) Means of injury fracture of left femur.

23. Signature W. — Toothaker (M. D. or other)

Address 620 Francis St. Joseph Mo Date signed 1-9-45

40630