

No. 2  
-8-43  
5-17-39  
X3823

DEPARTMENT OF COMMERCE  
BUREAU OF CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1871  
State File No. \_\_\_\_\_  
Registrar's No. 64

Registration District No. 55 Primary Registration District No. 3011

1. PLACE OF DEATH:  
(a) County Carroll  
(b) City or town Carrollton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Atwood Hosp.  
(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 Mo. (b) County Carroll  
(c) City or town Pura  
(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 DELLA SCHLETER  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb day 5 year 1946 hour 1 minute 30 P.M.  
21. I hereby certify that I attended the deceased from January 20 1946, to Feb. 5 1946 that I last saw her alive on Feb 4 1946 and that death occurred on the date and hour stated above.

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife E. F. Schleiter 6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased Apr. 20 (Month) (Day) (Year) 1881

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_  
Bronchio-pneumonia 3 days  
Due to secondary to  
Carcinoma of stomach  
Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy 4/6/46

8. AGE: Years 64 Months 9 Days 18 hr. \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace St. Louis Mo (City, town, or county) (State or foreign country)  
10. Usual occupation At Home

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Charles F. Brockman  
13. Birthplace St. Louis Mo (City, town, or county) (State or foreign country)  
14. Maiden name Minnie Hilmer  
15. Birthplace Germany (City, town, or county) (State or foreign country)  
16. (a) Informant Norma Schleiter  
(b) Address Carrollton, Mo  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-46 (Month) (Day) (Year)  
(c) Place: burial or cremation Oak Hill Cem.  
18. (c) Signature of funeral director Stanley Gibson  
(b) Address Carrollton Mo  
19. (a) 2/8/46 (Date received local registrar) (b) Mr. Herbert Calcutt (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 John H. Hay (M. D. or other) \_\_\_\_\_  
Address Carrollton Mo Date signed 2-7-46

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

3892

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

3-8-46

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

*Ben W. Gibson*

Licensed Embalmer No. 2961

P. O. Address

*Carrollton 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.