DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33113

Registration District No. 82 Primary Registration District No. 3017 Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Cooper
(b) City or town: Boonville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital (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 17-9-10

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Cooper 27
(c) City or town: Pilot Grove (Rural) 0 (If outside city or town limits, write "RURAL")
(d) Street No. ____ 0 (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: JUDITH-NAN-SCHLOTZHAUER
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: Female
5. Color or race: white
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: ✓
6. (c) Age of husband or wife if alive ____ years: ✓
7. Birth date of deceased: October (Month) 7 (Day) 1928 (Year)

8. AGE: Years 17 | Months 9 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace: Cooper County (City, town, or county) Mo. 6 (State or foreign country)
10. Usual occupation: ____
11. Industry or business: School girl
12. FATHER Name: Leonard Schlotzhauer
13. FATHER Birthplace: Cooper (City, town, or county) Mo. 0 (State or foreign country)
14. MOTHER Maiden name: Julia Cline
15. MOTHER Birthplace: Leavenworth (City, town, or county) Kansas (State or foreign country)
16. (a) Informant: Leonard Schlotzhauer
(b) Address: Pilot Grove, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 19 1946 (Month) (Day) (Year)
(c) Place: burial or cremation: Wesley Chapel Cem.
18. (a) Signature of funeral director: Hays-Painter
(b) Address: Pilot Grove, Mo.
19. (a) 11-15-46 (Date received local registrar) (b) D. E. Cooper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17 — year 1946 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from Dec 45, 19__, to 17 July 46, 19__; that I last saw her alive on 17 July 1946, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
pneumonia -terminal	2 days
Due to rheumatic heart disease	± 6 m
c cardiac decompensation	
Due to acute rheumatic fever	2 yrs.
Other conditions none (Include pregnancy within 3 months of death)	

Major findings: Of operations: none done
Of autopsy: none done

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
(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: Iris Cline Ravenscroft (M. D. or other) MD
Address: Boonville Mo Date signed: 18 July 46

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number 11-9

Date Filed 9th 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 Peyton E Hay

Licensed Embalmer No. 3074

P. O. Address Pilot Grove

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

If this body is not embalmed, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Non

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 125

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Boonville
(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 years, months or days)

In this community

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 Judith M. Schlotzhauer

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct 7 1928
(Month) (Day) (Year)

8. AGE: Years 17 Months Days If less than one day hr. min.

9. Birthplace Mo
(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) (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) 11-15-46 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Oct. Day 7 year 1946 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	
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

(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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

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

33113