No. 2
-11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 28 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7653

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 26

1. PLACE OF DEATH:
(a) County: Vernon
(b) City or town: Rural Walhington (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #3 2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 6 yrs 9 Mo 8 dys (Specify whether years, months or days)
In this community: 6 years 9 months 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: ✓ 108
(c) City or town: St Louis Mo 0 (If outside city or town limits, write "RURAL")
(d) Street No.: St Louis City Sanitorium 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? no years.

3. (a) PRINT FULL NAME: MINNIE SCHULTZ (SCHUTZ
3. (b) If veteran, name war: no
3. (c) Social Security No.:
4. Sex: Fem
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: unknown
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: unknown (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
53	?	?	— hr. — min.

9. Birthplace: unknown 9 (City, town, or county) (State or foreign country)
10. Usual occupation: Hospital Worker
11. Industry or business: ✓
12. Name (FATHER): unknown 9
13. Birthplace: ✓ unknown 9 (City, town, or county) (State or foreign country)
14. Maiden name (MOTHER): unknown
15. Birthplace: ✓ unknown 9 (City, town, or county) (State or foreign country)
16. (a) Informant: Hospital Record
(b) Address: Nevada Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-17-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Lock Cem
18. (a) Signature of funeral director: Eichinger Funeral Home
(b) Address: Neeraday Mo
19. (a) 2-20-47 (Date received local registrar) (b) Earl Lynn Yancey By Reed (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feby day: 15 year: 1947 hour: 5 minute: 35 A.M.
21. I hereby certify that I attended the deceased from Oct, 1939 to Feb 15, 1947 that I last saw her alive on Feb 15, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Cardio Renal Disease — Duration: few years
Due to: Hypertension —
Due to: Hypertensive Heart Disease
Other conditions (Include pregnancy within 3 months of death): Psychosis Especify Paranoid
Major findings: Of operations: none
Of autopsy: yes findings as above

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

22. If death was due to external causes, fill in the following: No
(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: Paul T. Barone (M. D. or other)
Address: State Hosp 3 Date signed: Feb 15
Nevada Mo

231 (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed by me, or by ....., Registered Apprentice No. ..... working under my personal supervision.

Signed Mark Eichinger

Licensed Embalmer No. 2656

P. O. Address Nevada, Mo.

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

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