

FILED AUG 28 1947

Registration District No. _____

Primary Registration District No. 3089

Registrar's No. 58

1. PLACE OF DEATH: Cape Girardeau

(a) County Cape Girardeau

(b) City or town Jackson

(c) Name of hospital or institution: West Main
(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

3. (a) PRINT FULL NAME Jimmie Ray Schroeder

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex M D 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 _____

7. Birth date of deceased June 17 1947
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|----------|-----------|----------------------|
| | | <u>1</u> | <u>29</u> | hr. _____ min. _____ |

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Gilbert Schroeder }
 { 13. Birthplace Bollinger County Mo. }
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Lucille Sides }
 { 15. Birthplace Cape Gir. County Mo. }
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Gilbert Schroeder
(b) Address Jackson Mo.

17. (a) Burial (b) Date thereof 8-17-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Russell Heights Cem.

18. (a) Signature of funeral director Wilson Staller Schaub
(b) Address Jackson Mo.

19. (a) 8-19-47 (b) D. G. Schuber
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Gir.

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

(d) Street No. West Main
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16
year 1947 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from Aug 12, 1947, to Aug 14, 1947
that I last saw him alive on Aug 12, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia 3 day
Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 10
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 10

28. Signature T. E. Ruff (M. D. or other) MD
Address _____ Date signed 8/18/47

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

Rev. 5-17-39
U.S. GPO: 1951 O-118511

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

Health Officer No. 4
Number 847-1104
8-27-47

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.....
..... Licensed Embalmer No.....
..... P. O. Address.....

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, above space should be left blank.