

Registration District No. 27 Primary Registration District No. 5091

1. PLACE OF DEATH:
 (a) County Bates
 (b) City or town Rural Rockville Twp
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 4 mi North West of Rockville Mo
(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 Betty Lou Schroder
 3. (b) If veteran, name war _____
 3. (c) Social Security No. none

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced 0
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec 6 1947
(Month) (Day) (Year)

8. AGE: Years _____ Months one Days 27
hr. min.

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

10. Usual occupation Baba

11. Industry or business _____

MOTHER FATHER
 12. Name ALFRED Schroder
 13. Birthplace Okla
(City, town, or county) (State or foreign country)
 14. Maiden name Ruby W. Scherck
 15. Birthplace Rockville Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Alfred Schroder
 (b) Address Rockville Mo

17. (a) Burial (b) Date thereof 2 5 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Appleton City Mo

18. (a) Signature of funeral director Frank
 (b) Address Appleton City Mo

19. (a) 2-5-48 (b) Frank
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Bates
 (c) City or town Rural Rockville Twp
(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 _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 2 day 3
 year 1948 hour 6 minute 30 a.m.
 21. I hereby certify that I attended the deceased from Jan. 10, 1948 to Feb. 2, 1948
 that I last saw her alive on Jan. 17, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial insufficiency Duration life
 Due to congenital heart. life
 Due to anemia & avitaminosis life
 Other conditions 15 7 1/2
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: none Performed
 Of operations _____
 Of autopsy none Performed
 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? _____
 While at work? _____
(Specify type of place) (e) Means of injury _____
 23. Signature M. D. Biske (M. D. or other) P.O.
 Address Rockville Mo Date signed 2/4/48

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

7000

RECEIVED

District Health Officer No. 7,

District File Number 2-48-294

Date Filed 3-26-48

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.....

on the 3d day of Feb 1948, Registered Apprentice No.....
working under my personal supervision:

Signed [Signature]

Licensed Embalmer No. 1099

P. O. Address Appleton City Ind

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.