

U.S. No. 2
FORM-5-43
REV. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35312**
Registrar's No. **73**

FILED NOV 5 1948
Registration District No. **61124**

Primary Registration District No. **61124**

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

1. PLACE OF DEATH:

(a) County **SCOTT**

(b) City or town **R.F.D.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **HOME**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **69 YEARS** (Specify whether years, months or days)

In this community **69 YEARS**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **SCOTT**

(c) City or town **R.F.D. COMMERCE**
(If outside city or town limits, write "RURAL")

(d) Street No. **✓** (If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **✓**

3. (a) PRINT FULL NAME **JOHN R. SCHERER**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **26**
year **1948** hour **12** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **Oct 10**, 19**48**, to **Oct 25**, 19**48**
that I last saw him alive on **Oct 25**, 19**48**
and that death occurred on the date and hour stated above.

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **AGNES** 6. (c) Age of husband or wife if alive **8 - 1879** years (Day) (Year)

7. Birth date of deceased **FEB. 8 - 1879** (Month) (Day) (Year)

Immediate cause of death:

Due to **Respiratory failure**

Due to **Coronary Occlusion** **2 minutes**

Due to **thrombus in the coronary artery**

Other conditions (Include pregnancy within 3 months of death)

8. AGE: Years **69** Months **8** Days **18** If less than one day **hr. min.**

9. Birthplace **Scott Co. Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

11. Industry or business **FARMING**

12. Name **JOHN B. SCHERER**

13. Birthplace **GERMANY** (City, town, or county) (State or foreign country)

14. Maiden name **MARY EISLE**

15. Birthplace **GERMANY** (City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: Of operations **g40**

Of autopsy

Underline the cause to which death should be charged statistically.

16. (a) Informant **MRS JOHN R. SCHERER**

(b) Address **R.F.D. COMMERCE, Mo**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **10-28-1948** (Month) (Day) (Year)

(c) Place: burial or cremation **NEW HAMBURG**

18. (a) Signature of funeral director **Walters Funeral Home**

(b) Address **Loafe Girardeau Mo**

19. (a) **10-26-48** (Date received local registrar) (b) **5. J. D. ...** (Registrar's signature)

22. If death was due to external causes, fill in the following:

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) (e) Means of injury **2**

23. Signature **Penton Wilson** (M. D. or other) **P.O.**

Address **Zornfelt** Date signed **Oct 26/48**

RECEIVED

District Health Office No. 2,

District File Number 1148-1489

Date Filed 11-4-48

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.....

....., Registered Apprentice No.....,
working under my personal supervision.

Signed.....

L. H. Hohler

Licensed Embalmer No.

4623

P. O. Address.....

Cape Stroudon W

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.