

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

26319
Do not use this space.

REC'D AUG 24 1939

1. PLACE OF DEATH
 (a) County New Madrid Registration District No. 663
 (b) Township West Primary Registration District No. 4257
 (c) City Morehouse (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Susan Schultz
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Gus Schultz</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>L. 15/70</u>		
7. AGE	YEARS <u>69</u>	MONTHS <u>6</u>
	DAYS <u>26</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Housework</u>	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Belmont Missouri</u>	
	13. NAME <u>Tom Underwood</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
	15. MAIDEN NAME <u>Unknown</u>	
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
17. INFORMANT <u>Tom A. Sheeter</u> (ADDRESS) <u>Morehouse Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Sikeston Mo.</u> DATE <u>8/12/39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Hunter Albritton</u> <u>Sikeston Mo. 536</u>		
20. FILED <u>8-22</u> 19 <u>39</u> <u>Mrs. John Parrish</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/11/39, 1939

22. I HEREBY CERTIFY, That I attended deceased from 8-9, 1939, to 8-11, 1939.
 I last saw her alive on 8-11, 1939. Death is said to have occurred on the date stated above, at 3:00 A.M.
 The principal cause of death and related causes of importance were as follows:
Generalized arteriosclerosis Date of onset 8-10-35
Chronic myocarditis

Other contributory causes of importance:
None known

Name of operation Stomach Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19_____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) J. A. Jones, M. D.
 (Address) Morehouse, Mo.

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.

52

RECEIVED

District Health Officer No. 2,
District File Number 839-166
Date Filed 8-23

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

26319^{*}
Do not use this space.

1. PLACE OF DEATH
(a) County New Madrid Registration District No. 603
(b) Township _____ Primary Registration District No. 438-7 Registered No. _____
(c) City Morehouse (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Susan Schultz
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS 69 MONTHS 6 DAYS 26 If LESS than 1 day, _____ hrs. or _____ min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-11-39
22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Generalized Carcinomatous Cancer of Stomach
Date of onset _____
Other contributory causes of importance: 40
Chronic Bronchitis
Chronic Myocarditis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19____

Name of operation None Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) H. A. Harris, M. D.
(Address) Morehouse Inst

Local Registrar.

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
AGE should be stated EXACTLY. PHYSICIANS should state whether or not of a contagious nature.

FILED IN 1939

S-26319
1939