

Registration District No. 144

Primary Registration District No. 51

Registrar's No. _____

1. PLACE OF DEATH:

(a) County McDonald
 (b) City or town Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
none Neosho RA
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
 (Specify whether

In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Marie Schumaker

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife Henry Schumaker 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 19 1857
 (Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name Not known

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

14. Maiden name Not known

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

16. (a) Informant's own signature Mrs. Ada Holyston

(b) Address Neosho Mo. RA 2

17. (c) Burial (b) Date thereof Feb 7 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elm. Burial Park

18. (a) Signature of funeral director W. M. ...

(b) Address Wheatland Mo.

19. (a) _____ (b) 414 (Registrar's signature)
 (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald
 (c) City or town Rural Neosho Mo RA 2
 (If outside city or town limits, write "RURAL")
 (d) Street No. none
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? not known years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5th
 year 1940 hour 10 minute 25 A. M.

21. I hereby certify that I attended the deceased from Jan 27 -
1940 to Feb 5 1940
 that I last saw her alive on Feb 4 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchio pneumonia Duration _____

Due to pneumonia

Due to sensitivity

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

Major findings: Of operations _____

Of autopsy _____

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 _____

28. Signature R. J. ... (M. D. or other) _____
 Address Neosho Mo Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically

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

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.

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.....

Wm. Morris Payne

....., Registered Apprentice No.

working under my personal supervision.

Signed

Wm. Morris Payne

Licensed Embalmer No. *3442*

P. O. Address

Wheaton Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11620

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 142

Primary Registration District No. 5693

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town One Sun
(c) Name of hospital or institution:

(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 Marie Schumaker

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased Oct 19 1857
(Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 15 If less than one day _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-70-40 (b) Chas. Swartz
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 21 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 R.C. Lawton (M. D. or other) _____

Address Neosho Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

11620

(1940)