

AUG 19 1940 334
Registration District No. _____

Primary Registration District No. **4197**

1. PLACE OF DEATH:

(a) County Harrison
(b) City or town Bethany
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(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) 5 20

3. (a) PRINT FULL NAME AMELIA MAINWARING SCHWENK

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

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

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

7. Birth date of deceased 5 16 1859
(Month) (Day) (Year)

8. AGE: Years 81 Months 1 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Irish Manuering

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

14. Maiden name Elizabeth

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

16. (a) Informant's own signature Beat S. Allen

(b) Address Bethany, Mo.

17. (a) Burial (b) Date thereof 5/12/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miriam

18. (a) Signature of funeral director J. M. Hase

(b) Address Bethany, Mo.

19. (a) 7-16-40 (b) J. G. P. Weiler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HARRISON
(c) City or town BETHANY
(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 7 day 15
year 1940 hour 12 minute 15 P. M.

21. I hereby certify that I attended the deceased from June 26, 1936, to July 15, 1940;
that I last saw her alive on July 15, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Acute ascending paralysis Duration 7/9
12/15

Due to _____

Due to Acute infarction June 25 1936

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

Major findings: Of operations No operation

Of autopsy None

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? 309

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature P. E. Larrudo (M.D. or other) _____
Address Bethany Mo Date signed 7/16/40

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.

RECEIVED
District Health Officer No. 11,
District File Number 840-1054
Date Filed AUG 9 1946

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..... *W B Haas*

Licensed Embalmer No..... *3899*

P. O. Address..... *Bethany 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.