

Registration District No. 494

Primary Registration District No. 3025

Registrar's No. 69

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Brunswick  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: McClain Hospital  
(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 Fred Bischoff 210

3. (b) If veteran, name war ✓ 3. (c) Social Security No. 352-10-8901

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife Nellie Bischoff 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 11 3 1900  
(Month) (Day) (Year)

8. AGE: Years 39 Months 8 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Carpenter

11. Industry or business ?

12. Name Theo. Bischoff

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

14. Maiden name Adelheid Springer

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

16. (a) Informant's own signature Nellie Bischoff

(b) Address Brewer

17. (a) Burial (b) Date thereof 8-7-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brewer

18. (a) Signature of funeral director A. J. Edwards

(b) Address Brewer

19. (a) Aug 1 40 (b) John Lucas  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn  
(c) City or town Brunswick  
(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.? 36 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1940 hour \_\_\_\_\_ minute 30 p. M.

21. I hereby certify that I attended the deceased from 7-30-40 to 7-31-40, 19\_\_\_\_, that I last saw him alive on 7-31-40, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Sepsis Duration 24h

Due to Pneumonia

Due to Postural sternal effusion Duration 13da

Other conditions 0

(Include pregnancy within 5 months of death)

Major findings: 12.1

Of operations 0

Of autopsy 0

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) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0

While at work? 0 (Specify type of place) (e) Means of injury 0

23. Signature John Lucas (M. D. or other)

Address Brunswick, Mo Date signed 7/31/40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo

RECEIVED

District Health Officer No. 11,

District File Number 840-1280

Date Filed AUG 6 1940

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.....

*H. Edwards*

....., Registered Apprentice No.....

working under my personal supervision.

Signed *H. Edwards*

Licensed Embalmer No. 1961

P. O. Address Brewer, 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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 25625-

Registration District No. 496

Primary Registration District No. 3025

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Brunswick  
(If outside city or town limits, write "RURAL" and name of township)  
(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 Fred Bischoff

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 Married

6. (b) Name of husband or wife Melis Bischoff 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 39 Months 8 Days 28 If less than one day \_\_\_\_\_ min.

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 \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 10.4.40 (b) [Signature] (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 \_\_\_\_\_ day \_\_\_\_\_  
\_\_\_\_\_ year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; 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 [Signature] (M. D. or other) \_\_\_\_\_

Address Brunswick Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

