

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 156 East Elm St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution not confined
(Specify whether
In this community True blue glass
years, months or days)

3. (a) PRINT FULL NAME LUTHER ARVILLE SCHOONAUER

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Louise Hermena Schoonauer 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased AUGUST 11 1893
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>56</u>	<u>11</u>	<u>21</u>	hr. _____ min.

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

10. Usual occupation Chiropractor

11. Industry or business Same

12. Name William Schoonauer

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

14. Maiden name Loelgia Buffington

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

16. (a) Informant Louise H. Schoonauer

(b) Address Springfield, Mo.

17. (a) Buried (b) Date thereof Aug 8 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's

18. (a) Signature of funeral director H. H. Gaudin

(b) Address Springfield, Missouri

19. (a) Aug 12 1940 (b) W. E. Vandrey
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limit, write "RURAL")
(d) Street No. 564 East Elm Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ✓ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2
year 1940 hour 8 15 minute A M.

21. I hereby certify that I attended the deceased from July 10, 1940, to Aug 2, 1940.
that I last saw him alive on Aug 10, 1940.
and that death occurred on the date and hour stated above.

Immediate cause of death Carbuncle of neck

Due to 54

Due to _____

Other conditions Diabetes Mellitis
(Include pregnancy within 3 months of death) Septemia

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? 9/11

(e) Means of injury _____
(Specify type of place) (Specify type of place)

23. Signature W. J. Walsh (M. D. or other) 9/2/40
Address Springfield Mo Date signed 9/2/40

Duration

1 mo

years

2 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 *Paul F. Stenley*

Licensed Embalmer No. *24517*

P. O. Address *Springfield*

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.

X