

SEP 14 1940
Registration District No. 744

Primary Registration District No. 3447-19

Registrar's No. 40

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

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural Jackson Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Stafford Route # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days) 39 years

3. (a) PRINT FULL NAME PETE SCHAEFER

8. (b) If veteran, name war None 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 Helen Mae Schaefer 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased May 8 1868
(Month) (Day) (Year)

8. AGE: Years 72 Months 1 Days 29 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name Pete Schaefer
13. Birthplace Germany
14. Maiden name Katharine Emerick
15. Birthplace Germany

16. (a) Informant Mrs. Pete Schaefer

(b) Address Stafford Route # 2

17. (a) Burial (b) Date thereof July 10, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenbayer

18. (a) Signature of funeral director F. C. Thieme

(b) Address Springfield, Mo.

19. (a) August 3-40 (b) Henry Jones
(Date received at local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Stafford Route # 2
(If rural, give location)
(e) If foreign born, how long in U. S. A. 68 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7th
year 1940 hour 10:45 minute A.M.

21. I hereby certify that I attended the deceased from 1-20-40
7-7-1940 to 7-7-1940

that I last saw him alive on 7-5-1940

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 6 2/3

Due to Chronic Hypertension

Due to Senility

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: none

Of operations none

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) no

(b) Date of occurrence no

(c) Where did injury occur? no
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

928 While at work? no
(Specify type of place) (Means of injury)

23. Signature J. F. Freeman (M. D. or other)

Address Springfield Date signed 7/14/40

RECEIVED

Greene County Health Office,

County File Number 40-9-~~10~~⁷⁰

Date Filed 9-12-40

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 R. H. Williams

Licensed Embalmer No. 3681

P. O. Address Springfield, 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.