No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29070

SEP 23 1940

Registration District No. 47

Primary Registration District No. 3079

Registrar's No. 251

1. PLACE OF DEATH:

(a) County: Marion

(b) City or town: Hannibal
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Enroute to Levering Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: Illinois (b) County: Macon

(c) City or town: Decatur
(If outside city or town limits, write "RURAL")

(d) Street No.: 913 North Morgan
(If rural, give location)

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

3. (a) PRINT FULL NAME: Charles W. Schroeder (Schrader) 636

3. (b) If veteran, name war ____

3. (c) Social Security No. 702-05-7209

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Corinda Schroeder

6. (c) Age of husband or wife if alive: 60 years

7. Birth date of deceased: October 6, 1877 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
62	10	22	____ hr. ____ min.

9. Birthplace: Fairmount (City, town, or county) W. Virginia (State or foreign country)

10. Usual occupation: Brakeman

11. Industry or business: Wabash R.R.

FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Corinda Schroeder
(b) Address: Decatur Illinois

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sep (Month) (Day) (Year)
(c) Place: burial or cremation: Decatur Graceland Cemetery

18. (a) Signature of funeral director: Crawford Smith
(b) Address: 902 Broadway, Hannibal

19. (a) 8-29-40 (Date received local registrar) (b) H. C. Gushes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: aug day: 28 year: 1940 hour: 6 minute: 15 a M.

21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__; that I last saw h. alive on ____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary thrombosis	
Due to:	
Due to: Angina	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations:	
Of autopsy:	

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? (Specify type of place)
While at work? yes (e) Means of injury: Coronary

23. Signature: James O'Donnell (M. D. or other)
Address: Hannibal Mo Date signed: 8-28-40

(Licensed Embalmer's Statement on Reverse Side)

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 Joseph J. March

Licensed Embalmer No. 3932

P. O. Address Hannibal, 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.