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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

**REC OCT 18 1940**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31986**

Registration District No. **305**

Primary Registration District No. **5422**

Registrar's No. **27**

1. PLACE OF DEATH: **GASCONADE**

(a) County **GASCONADE**

(b) City or town **ROSEBUD (CANAAN TOWNSHIP)**

(c) Name of hospital or institution: **ROSEBUD MO.**

(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) **20 YRS.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **GASCONADE**

(c) City or town **ROSEBUD**

(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.

3. (a) PRINT FULL NAME **JOHN SCHULTE**

3. (b) If veteran, name war **—**

3. (c) Social Security No. **—**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **SEPT.** day **14**

year **1940** hour **11** minute **15** A.M.

4. Sex **MALE**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **ANNA SCHULTE**

6. (c) Age of husband or wife if alive **DEAD** years

7. Birth date of deceased **SEPT. 22 1898**

(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept. 14 1940**

to **Sept. 14 1940**

that I last saw him alive on **Sept. 14 1940**

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

8. AGE:

Years	Months	Days	If less than one day
<b>81</b>	<b>11</b>	<b>22</b>	hr. <b>—</b> min. <b>—</b>

Immediate cause of death **Angina Pectoris**

Duration **1/2 hour**

9. Birthplace **MOISSOURI**

(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED FARMER**

11. Industry or business **—**

Due to **—**

Due to **—**

Other conditions (Include pregnancy within 3 months of death) **—**

Major findings: Of operations **—**

Of autopsy **—**

MOTHER FATHER

12. Name **DETRICH SCHULTE**

18. Birthplace **GERMANY**

(City, town, or county) (State or foreign country)

14. Maiden name **LOUISE ROETHMEYER**

15. Birthplace **GERMANY**

(City, town, or county) (State or foreign country)

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? **—**

16. (a) Informant **LINDA SCHULTE**

(b) Address **ROSEBUD MO.**

17. (a) **BURIAL** (b) Date thereof **9-16-1940**

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ROSEBUD M.E. CEM.**

18. (a) Signature of funeral director **W. F. Hattenstetter**

(b) Address **Owensville Mo.**

19. (a) **9-20-40** (b) **Paul A. Bannard**

(Date received local registrar) (Registrar's signature)

While at work? **—** (Specify type of place)

(e) Means of injury **—**

23. Signature **Paul A. Bannard** (M. D. or other) **—**

Address **Owensville, Mo.** Date signed **9-16-40**

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

**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 *me*

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

working under my personal supervision.

Signed *Milford H. H. Winter*

Licensed Embalmer No. *3838*

P. O. Address *Owensville 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.**