

REC'D OCT 18 1940

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 047

Primary Registration District No. 3029

Registrar's No. 275

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: Levering Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution August 30, 40  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Jennie Balfour Schutze

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife Harold Wm. Schutze 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased August 19, 1911  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
29 1 4 hr. min.

9. Birthplace Rocklake, North Dakota  
(City, town, or county) (State or foreign country)

10. Usual occupation Registered Nurse

11. Industry or business \_\_\_\_\_

12. Name Coy Eller

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

14. Maiden name Leaton Gleason

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

16. (a) Informant's name Harold W. Schutze

(b) Address 216 South Maple

17. (a) Burial (b) Date thereof 9/19/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Graceland Burial Park

18. (a) Signature of funeral director Carroll Smith

(b) Address 902 Broadway, Hannibal

19. (a) 9-18-40 (b) H. C. Fisher  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion  
(c) City or town Hannibal  
(If outside city or town limit, write "RURAL")  
(d) Street No. 216 South Maple  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 16  
year 1940 hour 7 minute 55P.M.

21. I hereby certify that I attended the deceased from Aug 30  
1940, to Sept 16, 1940;  
that I last saw he alive on Sept 16, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death

Rhinitis acuta

Due to 4 1/2 months fasting -  
Postoperative miscanosis - 14 days  
Due to General peritonitis - 14 days

Other conditions (Include pregnancy within 3 months of death) 140

Major findings:

Of operations ① 8-30-40 Rhinitis acuta  
② 9-8-40 General peritonitis

Of autopsy \_\_\_\_\_

Duration

18 days

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? Y

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

23. Signature Harold Madril (M. D. or other) M.D.  
Address Hannibal Mo Date signed 9-17-40

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 Joseph J. Marsh

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.**