

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. **35001**  
Registrar's No. **35**

NOV 15 1940 / 24

Registration District No. \_\_\_\_\_

Primary Registration District No. **4070**

## 1. PLACE OF DEATH:

- (a) County CAPE GIRARDEAU  
 (b) City or town JACKSON  
 (c) Name of hospital or institution: \_\_\_\_\_  
 (If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)

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

3. (a) PRINT FULL NAME William F. Schade

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife JENNIE THOMPSON SCHADE 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased DECEMBER 22 1865  
 (Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Stockman

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

12. Name August Schade13. Birthplace AK  
 (City, town, or county) (State or foreign country)14. Maiden name Elizabeth Brand15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)16. (a) Informant's own signature Albert Illers(b) Address Jackson MO

17. (a) Burial (b) Date thereof Oct 6-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation RUSSELL HEIGHTS CEM18. (a) Signature of funeral director Macke-Wilson-Statler(b) Address JACKSON MO

19. (a) 10-5-40 (b) D. L. Seiber  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CAPE GIRARDEAU(c) City or town JACKSON  
 (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.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4  
 year 1940 hour 3 minute 15 a.m.

21. I hereby certify that I attended the deceased from 10-26-39  
 \_\_\_\_\_, 19\_\_\_\_, to 10-3, 1940;

that I last saw him alive on 10-3-, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary Edema  
 Due to Chronic Myocarditis

Due to with aneurysm

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

Major findings:  
 Of operations arteriosclerosis

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

Duration

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? 

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

23. Signature Albert Illers (M. D. or other) MD  
 Address Jackson MO Date signed 10-5-40

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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.....

Glenn Wilson, Registered Apprentice No. ....  
working under my personal supervision.

Signed Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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.**

Registration District No. 124

Primary Registration District No. 4070

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town Jackson  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
in this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Wm F Shade  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
74 9 12 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5-26-41 (b) D. G. Sibert  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Oct day 4  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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?

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

23. Signature Albert M. Estes (M. D. or other)

Address Jackson, Mo. Date signed \_\_\_\_\_

HOWENA MOORE

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

SUPPLEMENTARY

