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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. 35257

FILED NOV 1 1940 FILED NOV 15 1940

Registration District No. 29 Primary Registration District No. 3016 Registrar's No. 100

**1. PLACE OF DEATH:**
(a) County Franklin
(b) City or town Washington Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks (Specify whether years, months or days)
In this community 9 yrs. 4 mo.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County Franklin
(c) City or town Washington Mo. (If outside city or town limits, write "RURAL")
(d) Street No. 205 - N. 3rd St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME CHARLES LAWRENCE SCHARFENBERG
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Alberta Laugay Scharfenberg
6. (c) Age of husband or wife if living 37 years
7. Birth date of deceased Oct (Month) 10 (Day) 1897 (Year)

8. AGE: Years 43 Months 0 Days 20 If less than one day ____ hr. ____ min.

9. Birthplace Union Mo (City, town, or county) (State or foreign country)
10. Usual occupation Shop machinist
11. Industry or business Shop worker
FATHER
12. Name Joseph Scharfenberg
13. Birthplace Union Mo (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Anna Steuterman
15. Birthplace Washington Mo (City, town, or county) (State or foreign country)
16. (a) Informant Gertrude C. Scharfenberg
(b) Address Washington Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29. 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Mo.
18. (a) Signature of funeral director Otto Rec
(b) Address Washington Mo
19. (a) Oct. 28-1940 (Date received local registrar) (b) H. A. May (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 27 year 1940 hour 2 minute 55 A.M.
21. I hereby certify that I attended the deceased from Dec 3 1939 to Oct 27 1940 that I last saw him alive on Oct 26 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis of Lungs, Chronic — Duration 1930
Due to Bad Kidneys 3 yr
Due to Poor Kidneys 3 yr
Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations no operation
Of autopsy no 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? No
While at work? (Specify type of place) (e) Means of injury

23. Signature R. R. Cilley M.D. (M. D. or other)
Address Washington Mo. Date signed Oct 27 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 none

other, Registered Apprentice No. none,

working under my personal supervision.

Signed Henry W. Otto

Licensed Embalmer No. 3560

P. O. Address Washington

**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.**