

No. 2
-12-40
17-39
X23159

NOV 21 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36214

State File No. _____

Registration District No. 750

Primary Registration District No. 5994

Registrar's No. 1704

1. PLACE OF DEATH:

(a) County Ripley
(b) City or town Rural Union
(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 20
In this community 40 yrs.
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ripley
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Union township
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME James Andrew Schlachter

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Lela Schlachter 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased April 11 1877
(Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation farmer

11. Industry or business _____

12. Name Joseph Schlachter

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

14. Maiden name unknown

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

16. (a) Informant Lela Schlachter

(b) Address Marmesburg, Ark. Rt. # 1

17. (a) Burial (b) Date thereof 10/28/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Johnson Chapel

(e) Signature of funeral director Black's Mortuary

(b) Address Doniphan, Mo.

19. (a) 10-28-1940 (b) C. B. Johnston
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 26
year 1940 hour 8 minute 30 AM.

21. I hereby certify that I attended the deceased from Oct 1-1940
Oct 26 1940 to 19;
that I last saw him alive on Oct 22 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Oct 26-40

Due to _____
Due to _____

Other conditions g.i.t.
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration
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?
674 (Specify type of place)

(e) While at work? (Specify type of place) (f) Clifford Jofort
Signature (At. D. or other)

Address _____ Date signed _____

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, ~~and~~.....

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

working under my personal supervision.

Signed.....

Leslie D. Russell

Licensed Embalmer No. 3853

P. O. Address... Corning, Ark.

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, fact should be so stated above.