

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.

JAN 20 1941 508.
Registration District No.

Primary Registration District No. 3026.

1. PLACE OF DEATH:
(a) County Linnington
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
500 Williams St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 35 yrs years, months or days

3. (a) PRINT FULL NAME Hazel Bell Schaffer
8. (b) If veteran, name war ✓ 8. (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 Fred C. Schaffer 6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased Aug 1 1893
(Month) (Day) (Year)

8. AGE: Years 47 Months 4 Days 11 If less than one day hr. min.

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

10. Usual occupation at home

MOTHER FATHER
11. Industry or business _____
12. Name Maxwell T. Stewart
13. Birthplace Farber, Neb
(City, town, or county) (State or foreign country)
14. Maiden name Estel Matye
15. Birthplace Unknown Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hazel Schaffer
(b) Address 3307 Park, Kansas City, Mo
17. (a) Burial (b) Date thereof Dec 13 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Chillicothe, Mo
18. (a) Signature of funeral director Ronald T. Gordon
(b) Address Chillicothe, Mo
19. (a) 12-14-40 (b) R. T. Grace, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Linnington
(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")
(d) Street No. 500 Williams St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 13 year 1940 hour 5 minute _____ P. M.
21. I hereby certify that I attended the deceased from Jan 1938 to Dec 12 1940
that I last saw her alive on Dec 10 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of lungs right Duration 6 mos
Due to Cancer of breast 2 yrs
Due to _____
Other conditions (Include pregnancy within 3 months of death) 50

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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 None
(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? None
(Specify type of place) (e) Means of injury _____
23. Signature R. T. Grace (M. D. or other) _____
Address Chillicothe, Mo Date signed 12/13/40

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: *Ronald F. Gardner*

Licensed Embalmer No. *4191*

P. O. Address: *Chillicothe, 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.