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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 14 1941
318

Registration District No.

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2001

State File No. 2627

Registrar's No. 77

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 402 / HOVEY
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene 39

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")

(d) Street No. 402 Hovey 6
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME MARY A. SCHAEFFER

3. (b) If veteran, name war None

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Franklin R. Schaeffer

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Feb 11 (Month) 3 (Day) 1862 (Year)

8. AGE: Years 78 Months 11 Days 26 If less than one day ..... hr. ..... min.

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

10. Usual occupation House Wife

11. Industry or business In home

FATHER
12. Name Peter Maschino
13. Birthplace Unknown (City, town, or county) France (State or foreign country)

MOTHER
14. Maiden name Elizabeth Maschino
15. Birthplace Unknown (City, town, or county) France (State or foreign country)

16. (a) Informant Ammon D. Schaeffer
(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1-1941 (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn

18. (a) Signature of funeral director J. W. Klingner & Co.
(b) Address Springfield, Mo.

19. (a) 2-1-41 (Date received local registrar) (b) W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 29 year 1941 hour 2 minute 00 A. M.

21. I hereby certify that I attended the deceased from Oct 32, 1932, to Jan 28, 1941; that I last saw her alive on Jan 28, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arteriosclerotic heart disease	10 yrs
Due to: Auricular fibrillation	48 hrs
Due to: Embolism cerebral	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy (Verified)	

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

23. Signature Robert Glynn (M. D. or other) MW
Address Springfield Mo. Date signed 4/29/41

(Licensed Embalmer's Statement on Reverse Side)

OCT 10 1956

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 William Max Rhode

Licensed Embalmer No. 4071

P. O. Address Springfield, O

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.