

Registration District No. **264**

Primary Registration District No. **5627**

Registrar's No. **12**

1. PLACE OF DEATH:

(a) County **Lafayette**
(b) City or town **Rural Sniabar Twp. Mo.**
(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 **40 Yrs.**
In this community **40 Yrs.**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lafayette**
(c) City or town **Rural Odessa**
(If outside city or town limits, write "RURAL")
(d) Street No. **6 Mi. SW of Odessa**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **11** year **1941** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **July 5, 1940** to **Feb 4, 1941**, that I last saw him alive on **Feb 4** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Artery Disease**

Due to **Hypertension**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **43 W**

Major findings: Of operations _____

Of autopsy _____

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? **101**

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

23. Signature **[Signature]** (M. D. or other) _____

Address **[Address]** Date signed **2/3/41**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **William N. Schrimsher**

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 **Sarah A. Schrimsher** 6. (c) Age of husband or wife if alive **72** years

7. Birth date of deceased **Nov. 1 1862**
(Month) (Day) (Year)

8. AGE: Years **78** Months **3** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **Johnson Co., Indiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Hugh N. Schrimsher**

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

14. Maiden name **Mary G. Scott**

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

16. (a) Informant **Mrs. Sarah Schrimsher**

(b) Address **Odessa, Mo.**

17. (a) **Burial** (b) Date thereof **Feb. 13, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Concord Cem. Odessa**

18. (a) Signature of funeral director **[Signature]**

(b) Address **[Address]**

19. (a) **2/12/41** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

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

Date Filed 3-5-41
District File Number
Health Officer No. 8,

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 George L. Husman

Licensed Embalmer No. 7541

P. O. Address Obena, 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.