

FILED APR 21 1941

Registration District No. 765

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4460

11879

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St Clair
(b) City or town Osceola
(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 _____ (Specify whether
In this community 65+ years years, months or days)3. (a) PRINT FULL NAME Amos W Schoonover

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 married6. (b) Name of husband or wife Minnie Weaver 6. (c) Age of husband or wife if alive 66 years7. Birth date of deceased. 3-2-1861
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
79 9 29 hr. min.9. Birthplace Kirkville Mo
(City, town, or county) (State or foreign country)10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER
12. Name Thos G
13. Birthplace Barbour Co W. Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Emelia Mattheis
15. Birthplace Barbour Co W. Virginia
(City, town, or county) (State or foreign country)16. (a) Informant Mrs Minnie Schoonover(b) Address Osceola17. (a) Burial (b) Date thereof 1-3-1941
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Osceola Mo18. (a) Signature of funeral director G. S. H. Hill(b) Address Osceola19. (a) 1-10-41 (b) Paul Weaver
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Clair 93
(c) City or town Osceola 2
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 1
year 1940 hour 5 minute 45 P M.21. I hereby certify that I attended the deceased from _____, 1938, to _____, 19____;that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration

acute catarrhal colitis 12-15-40Due to a chronic colitis of many
years standing.

Due to _____ 2

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations none 120 NOf autopsy none

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? _____

While at work _____ (Specify type of place)

(e) Means of injury 023. Signature Paul Weaver (M. D. or other M.D.)

Address _____ Date signed _____

RECEIVED

District Health Officer No. 7,

District File Number 4/41/725-

Date Filed 4/17/46

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11879

Registration District No. 765-

Primary Registration District No. 4460

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Osceola
(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..... (Specify whether

In this community.....
years, months or days)

3. (a) PRINT FULL NAME Amos W. Schoonover

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 m

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 79 Months 9 Days 29 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....
19. (a) 6-7-1941 (b) Ruth Seavers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair
(c) City or town Osceola mo
(If outside city or town limits, write "RURAL")

(d) Street No..... (If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 1 day 1
year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....

that I last saw him..... on..... and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration.....

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?.....

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

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN..... Underline the cause to which death should be charged statistically.

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

23. Signature Ruth Seavers (M. D. or other).....

Address Osceola mo Date signed.....

SUPPLEMENTARY

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

11879

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.....

Licensed Embalmer No.....

P. O. Address.....

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.