No. 2
4-13-40
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILLED JUN 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17564

Registration District No. 198 Primary Registration District No. 3011 Registrar's No. 66

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution: Excelsior Springs Osteopathic Sani. Inc. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 25 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Minn. (b) County Martin 799

(c) City or town Fairmont 21 (If outside city or town limits, write "RURAL")

(d) Street No. 205 Cambridge (If rural, give location)

(e) If foreign born, how long in U. S. A.? 61 yr 2 years.

3. (a) PRINT FULL NAME OTTO SCHMIDTKE

3. (b) If veteran, name war No

3. (c) Social Security No. 473-12-9893

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife ✓

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

7. Birth date of deceased Oct (Month) 27 (Day) 1877 (Year)

8. AGE: Years 63 Months 6 Days 13 If less than one day ___ hr. ___ min.

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

10. Usual occupation Janitor in School

11. Industry or business

FATHER
12. Name Carl Schmidtke
13. Birthplace unknown (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Henrietta Wuske
15. Birthplace unknown (City, town, or county) Germany (State or foreign country)

16. (a) Informant Wm A Schmidtke

(b) Address 1329 N Rosie Fairmont

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/10/41 (Month) (Day) (Year)

(c) Place: burial or cremation Fairmont Minn

18. (a) Signature of funeral director Herbert Hofer

(b) Address Excelsior Springs Mo

19. (a) May 10 1941 (Date received local registrar) (b) Mrs Ed McCracken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 10th year 1941 hour one minute 47 A.M.

21. I hereby certify that I attended the deceased from Apr. 16th, 1941, to May 10, 1941, that I last saw him alive on May, 10, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE

Due to arteriosclerosis & Hypertension

Due to

Other conditions (Include pregnancy within 3 months of death) 87 N

Major findings:
Of operations

Of autopsy

Duration

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 J. D. Huff (M.D. or other) DD

Address Excelsior Springs, Mo Date signed 5/10/41

(Licensed Embalmer's Statement on Reverse Side)

DEC 29 1940

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-12-41

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 Chas Virgil Hope

Licensed Embalmer No. 3950

P. O. Address Excelsior Springs

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.