No. 2
-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24580

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 822

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 days (Specify whether years, months or days)
In this community: 9 years 0

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan 011
(c) City or town: St. Joseph 1
(If outside city or town limits, write "RURAL")
(d) Street No.: 3038 Felix Street 7
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Max Gustav Schuchardt
3. (b) If veteran, name war: none
3. (c) Social Security No. 487-14-5805
4. Sex: male 0
5. Color or race: white
6. (a) Single, widowed, married, divorced: married 1
6. (b) Name of husband or wife: Frieda E.
6. (c) Age of husband or wife if alive: 67 years
7. Birth date of deceased: November (Month) 15 (Day) 1861 (Year)
8. AGE: Years 79 Months 8 Days 29 If less than one day ___ hr. ___ min.
9. Birthplace: Greussen in Thueringen Germany 4
(City, town, or county) (State or foreign country)
10. Usual occupation: Retired
11. Industry or business: Cemetery
MOTHER FATHER
12. Name: Wilhelm Schuchardt
13. Birthplace: Thueringen (City, town, or county) Germany 4 (State or foreign country)
14. Maiden name: Ida Henne
15. Birthplace: Thueringen (City, town, or county) Germany 4 (State or foreign country)
16. (a) Informant: Carl P. Schuchardt
(b) Address: 3038 Felix St., St. Joseph, Mo.
17. (a) cremation (Burial, cremation, or removal) (b) Date thereof: Aug. 16, 1941 (Month) (Day) (Year)
(c) Place: D. W. Newcomer's Sons, Kansas City, Missouri
18. (a) Signature of funeral director: Walter Meierhoffer
(b) Address: 1302 Faraon, St. Joseph, Missouri
19. (a) Aug 16-1941 (Date received local registrar) (b) A. J. Kerkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 14 year 1941 hour 7 minute 40 p. m.
21. I hereby certify that I attended the deceased from August 10, 1941, to August 14, 1941; that I last saw him alive on August 8-14, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Nephritis Arteriosclerotic — Duration ?
Due to: Arteriosclerosis general — Duration ?
Due to:
Other conditions: Uremia
(Include pregnancy within 3 months of death)
Major findings:
Of operations: —
Of autopsy: —

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): No
(b) Date of occurrence: No
(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: [illegible] (M. D. or other) M. D.
Address: Phys. & Surg. Bldg. Date signed 8-15-41

(Licensed Embalmer's Statement on Reverse Side) St. Joseph, Mo.

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

SEP 12 1941

JUN 12 1948

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 Oby JEster

Licensed Embalmer No. Mo. 4154

P. O. Address St. Joseph, Missouri

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.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24580

Registration District No. 35 Primary Registration District No. 1001 Registrar's No. 822

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(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 years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (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

3. (a) PRINT FULL NAME: Max G. Schuchardt
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex
5. Color or race
6. (a) Single, widowed, married, divorced
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 Months Days 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
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. Day 4 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.
Immediate cause of death Nephritis - arteriosclerotic — Duration
Due to arteriosclerosis
Due to [redacted]
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.

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)
(b) 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

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