

SEP 11 1944
Registration District No. 1158

Primary Registration District No. 5296A

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Cole
(b) City or town St. Thomas
(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 _____
In this community 59 yr. 1 (Specify whether years, months or days)

8. (a) PRINT FULL NAME JOSEPH J. Schmidt

8. (b) If veteran, name war NONE 8. (c) Social Security No. NONE

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife CHRISTINE M. Schmidt 6. (c) Age of husband or wife if 72 years

7. Birth date of deceased Dec. 18 1866
(Month) (Day) (Year)

8. AGE: Years 7+ Months 7 Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Farmer

11. Industry or business NONE

12. Name Bernard Schmidt

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

14. Maiden name Anna Mary Bruno

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

16. (a) Informant Christine Schmidt

(b) Address St. Thomas Mo.

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

(c) Place: burial or cremation St. Thomas

18. (a) Signature of funeral director H. H. Strop

(b) Address _____

19. (a) _____ (b) _____ (c) _____ (d) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cole
(c) City or town St. Thomas
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 59 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18th year 1944 hour 25 o'clock minute 30 P. M.

21. I hereby certify that I attended the deceased from January the 20th 1944 to August 18th 1944; that I last saw him alive on August the 18th 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 3 Days

Due to Chronic diffuse Nephritis

Due to Senility

Other conditions 1921
(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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature Henry C. Warner (M. D. or other) D

Address St. Thomas Mo. Date signed Sept 27 1944

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

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

H H Sharp

Licensed Embalmer No.

2924

P. O. Address

Meta Mo

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

If this body is not embalmed, above space should be left blank.

STANDARD CERTIFICATE OF DEATH

State File No. 28125-

Registration District No. 1158

Primary Registration District No. 5296

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Cole
(b) City or town St. Thomas
(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)

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 Joseph J. Schmidt

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 _____ Months _____ Days _____ (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

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. St. Thomas Cemetery (b) Date there Aug. 21st 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. Aug. 21st 1941 (b) Dr. H. C. Wesner
(Date to receive local registrar) (Registrar's signature)
By J. A. ... Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

