

No. 2
-1-4-41
5-17-39
26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31044**
Registrar's No. **947**

Registration District No. **625**

Primary Registration District No. **1001**

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution:
905 N. 18th.
(d) Length of stay: In hospital or institution 68 Years
In this community 68 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Buchanan
(c) City or town St. Joseph
(d) Street No. 905 N. 18th.
(e) Citizen of foreign country? No.

3. (a) PRINT FULL NAME PHILIP SCHUNDER
3. (b) If veteran, name war None
3. (c) Social Security No. None

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 May 13th. 1868

8. AGE: Years 73 Months 4 Days 17
If less than one day hr. min.

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

10. Usual occupation Plasterer

11. Industry or business

MOTHER FATHER { 12. Name Schunder
13. Birthplace Unknown Germany
14. Maiden name Anna Marie Dorst
15. Birthplace Unknown Germany

16. (a) Informant Mrs. Nellie Abbey
(b) Address 705 Main St. Joseph, Mo.

17. (a) Burial (b) Date thereof 10--2--41
(c) Place: burial or cremation Mt. Mora Cemetery

18. (a) Signature of funeral director FLEEMAN & SON INC,
(b) Address St. Joseph Mo.

19. (a) Oct. 1, 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 30
year 1941 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from 9-27 to 9-30-41
that I last saw him alive on 9-30-41
and that death occurred on the date and hour stated above.

Immediate cause of death arterio sclerosis
Duration 5 yrs

Due to [Signature]

Due to 91

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations None
Of autopsy None
PHYSICIAN [Signature]
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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature [Signature] (M. D. or other) [Signature]
Address 2802 [Address] Date signed 9/1/41

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, ~~and~~.....

9-30-41

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Geo. E. Daniel

..... Licensed Embalmer No.....

3300

P. O. Address.....

St Joseph 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, fact should be so stated above.