

No. 2
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DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

BUREAU OF THE CENSUS
FILLED NOV 18 1941

State File No. 35062

Registration District No. 347

Primary Registration District No. 3018

Registrar's No.

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton, Mo.
(c) Name of hospital or institution 324 W Green
(d) Length of stay: In hospital or institution 8 yrs 1
In this community 8 yrs 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town Clinton
(d) Street No. 324 W Green
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Ruben O Schmitt

3. (b) If veteran, name war ✓ 3. (c) Social Security No. 500-07-0017

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Bertha Schmitt (c) Age of husband or wife if alive 7 years

7. Birth date of deceased (Month) 6 (Day) 7 (Year) 1890

8. AGE: Years 51 Months 4 Days 15 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Gies Schmitt

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

14. Maiden name Unknown

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

16. (a) Informant Bertha Schmitt (b) Address Clinton Mo

17. (a) Burial (b) Date thereof 10 24 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Loury City, Mo

18. (a) Signature of funeral director Ed Williams (b) Address Clinton Mo

19. (a) 10-22-41 (b) Dr. J. R. Hampton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22 year 1941 hour 1 minute 30 P.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 This man had long been in hospital because of heart attack due to of pain in cardiac region - not found when I arrived

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? _____

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

23. Signature J. L. Walker (M. D. or other) M.D.
Address Clinton Mo Date signed 10-24-41

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District File Number

11-41-1896

Date filed

11-14-41

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

Fred Wilkerson

Licensed Embalmer No.

2478

P. O. Address

Clinton

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. 35062

Registration District No. 347

Primary Registration District No. 3018

Registrar's No.

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Clinton
(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 Ruben O Schmitt

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct year 1941 hour _____ minute _____ M.

4. Sex M 5. Color or race W 6. (e) 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 June 7 1890
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

8. AGE: Years 51 Months 4 Days _____
If less than one day _____ min.

Immediate cause of death This man had had form of heart disease hospital year. Had attack. Due to my point in cardiac region was dead when I arrived.

Due to Coronary sclerosis

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

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

Major findings: _____
Of operations 94a

10. Usual occupation _____

11. Industry or business _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

18. (a) Signature of funeral director _____ (b) Address _____

(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 _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

23. Signature H. S. Walker (M. D. or other) M.D.
Address Clinton Mo Date signed 12-12-41

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

SUPPLEMENTARY

MOTHER FATHER

