

No. 2  
4-13-40  
-17-39  
I X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

39630

FILED DEC 3 1941

State File No. \_\_\_\_\_

Registration District No. 959

Primary Registration District No. 6063a

Registrar's No. 1

1. PLACE OF DEATH:  
 (a) County Scott  
 (b) City or town Royal Morkand Twp  
(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 23 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED: 100  
 (a) State Missouri (b) County Scott 0  
 (c) City or town Royal Morkand Twp 0  
(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.? 0 years.

3. (a) PRINT FULL NAME Nicholas Schwosser  
 3. (b) If veteran, name war ✓  
 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Nov day 24  
 year 1941 hour 3 minute 0 M.  
 21. I hereby certify that I attended the deceased from on  
11/24, 1941, to \_\_\_\_\_, 1941  
 that I last saw him alive on 11/24, 1941  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Olga Catherine Schwosser  
 6. (c) Age of husband or wife if alive 68 years  
 7. Birth date of deceased April 23 1858  
(Month) (Day) (Year)

Immediate cause of death  
Cerebral Hemorrhage Duration 3 hours

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>7</u>	<u>1</u>	_____ hr. _____ min.

Due to Vascular Hypertension?  
 Due to \_\_\_\_\_  
 Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace New Hamburg Scott Co Mo  
(City, town, or county) (State or foreign country)

Major findings:  
 Of operations 430  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

10. Usual occupation Farmer  
 11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Mathias Schwosser  
 13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)  
 14. Maiden name Mary Schmitt  
 15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Stephen Schwosser  
 (b) Address Benton Mo R2D.

17. (a) Burial (b) Date thereof 11-26-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St Lawrence - New Hamburg Mo

18. (a) Signature of funeral director Bisplinghoff & Hubbard  
 (b) Address Chiffre Mo

19. (a) 11-25-41 (b) Cyril Dimberger  
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury TD  
 23. Signature J. A. Cline (M. D. or other) \_\_\_\_\_  
 Address Oran Mo Date signed 11/27/41

(Licensed Embalmer's Statement on Reverse Side)

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 *Mamie Buehlinghoff*

Licensed Embalmer No. *3243*

P. O. Address *Chaffee 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.**