S. No. 2
M—9-4-41
v. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 15 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12182

Registration District No. 746795 Primary Registration District No. 4476 Registrar's No. 52

97
0
0

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

1. PLACE OF DEATH:

(a) County SALINE
(b) City or town MALTA Bend Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: No 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 14 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County SALINE 97
(c) City or town MALTA Bend 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Sophia E Schroeder

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

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Otto Schroeder
6. (c) Age of husband or wife if alive 41 years
7. Birth date of deceased Dec (Month) 1 (Day) 1905 (Year)

8. AGE: Years 36 | Months 3 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Forrest City (City, town, or county) Penn 1 (State or foreign country)
10. Usual occupation House Wife
11. Industry or business .....

FATHER
12. Name Adolph Skrocki
13. Birthplace KALVI (City, town, or county) Poland 4 (State or foreign country)

MOTHER
14. Maiden name ALERERANDA Zbrezne
15. Birthplace KALVI (City, town, or county) Poland 4 (State or foreign country)

16. (a) Informant Mr Otto Schroeder
(b) Address MALTA Bend Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18 1942 (Month) (Day) (Year)
(c) Place: burial or cremation St Mary, Cem.
18. (a) Signature of funeral director Don Short
(b) Address MARSHALL Mo
19. (a) Mar 17 1942 (Date received local registrar) (b) Mrs T. O. Westbrook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15 year 1942 hour 12 minute 10 AM.

21. I hereby certify that I attended the deceased from held in guest March 15, 1942, 19....; that I last saw h— alive on —, 19....; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to .....

Due to .....

Other conditions ..... (Include pregnancy within 3 months of death) 830

Major findings:
Of operations ✓
Of autopsy No

Duration

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury ..... Saline Co.

23. Signature C. L. Lawless Coroner (M. D. or other)
Address Marshall Mo Date signed 3-16-42

1215 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number _____

Date Filed 4-14-42

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 Don Shat

Licensed Embalmer No. 3757

P. O. Address Marshall 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.