

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

17557

State File No.

Registrar's No.

Registration District No. 89

Primary Registration District No. 3087

## 1. PLACE OF DEATH:

(a) County Butler  
 (b) City or town Poplar Bluff  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Lucy Lee Hosp.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 Weeks  
 (Specify whether years, months or days) 30 Years

3. (a) PRINT FULL NAME Florence Schwaner

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug. 20, 1895  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
46 8 17 \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Bonne Terre Mo.  
(City, town, or county) (State or foreign country)10. Usual occupation Social Security Office

11. Industry or business \_\_\_\_\_

12. Name Unknown  
13. Birthplace Unknown  
(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 Mrs Al Monk  
(b) Address Columbia Mo.17. (a) Burial (b) Date thereof May 8, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Woodlawn18. (a) Signature of funeral director Frank Mortuary(b) Address Poplar Bluff Mo.19. (a) 8-8-42 (b) Belle Turner  
(Data received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler  
 (c) City or town Poplar Bluff  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 847 Pine St.  
 (If rural, give location) no  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7  
year 1942 hour 11 minute 00 A. M.21. I hereby certify that I attended the deceased from April 3 to May 7, 1942  
that I last saw the deceased alive on May 7, 1942  
and that death occurred on the date and hour stated above.Immediate cause of death SepticemiaDue to Pelvic abscess

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

14 days30 days

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) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Poplar Bluff Mo. Date signed 5/8/42

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

RECEIVED

District Health Office, No. 2,

District File Number 642-75-8

Date Filed JUN 18 1942

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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. 17557

Registration District No. 89

Primary Registration District No. 3007

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: Butler

(a) County \_\_\_\_\_

(b) City or town Paplar Bluff  
(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 Florence Schwaner

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him/her on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 20  
(Month) (Day) (Year)

Immediate cause of death abscess

Due to non purperal

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 46 Months 8 Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ min.

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

1390

10. Usual occupation \_\_\_\_\_

11. Industry or 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)

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 \_\_\_\_\_

23. Signature [Signature] M.D. or other \_\_\_\_\_  
Address Paplar Bluff Mo Date signed 3/26/42

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

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

SUPPLEMENTARY

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

MOTHER FATHER

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

