FILED AUG 7 1942

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

25450
Do not use this space.

1. PLACE OF DEATH

(a) County Scott — Registration District No. 816 — 100

(b) Township Kiko — Primary Registration District No. 6065 — 0

(c) City R.F.D. Chaffee — (d) Street No. / St. — 0 — Registered No. 9

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Leon George Schetter

(a) Residence, No. St. 0

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male 0

4. COLOR OR RACE: White 0

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 6, 1905

7. AGE: Years 37 | Months 1 | Days 28 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Day Labor

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Hamburg Missouri 0

FATHER

13. NAME Louie Schetter

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Hamburg Mo. Scott Co. 0

MOTHER

15. MAIDEN NAME Louise Hagen

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Hamburg Mo. Scott Co. 0

17. INFORMANT (ADDRESS) Theon Schetter Chaffee Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE New Hamburg Mo. DATE July 6, 1942

19. FUNERAL DIRECTOR (NAME) [illegible] (ADDRESS) 113 W. Yoakum-Chaffee Missouri

20. FILED July 6th, 1942 Mrs. A. H. Dana Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) , 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ....m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Suicide by drinking carbolic acid	

Other contributory causes of importance:

1637

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Suicide Date of injury 7-4, 19 42

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) [illegible] (Address) Grau, Scott Co

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Office No. 2,
District File Number 842-965
Date Filed 8-4-42

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.....

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, above space should be left blank.

. S. No. 2B
OM—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25450

Registration District No. 816 Primary Registration District No. 6065 Registrar's No. 9

1. PLACE OF DEATH:

(a) County: Scott

(b) City or town: Rural
(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: Leon G. Schetter

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: May (Month) 6 (Day) 1943 (Year)

8. AGE: Years 37 Months 6 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 4th 1943
year hour minute 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

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)

(b) 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY