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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 10 1942

Registration District No. 273

Primary Registration District No. 5915

Registrar's No. 70

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

1. PLACE OF DEATH:

(a) County Perry

(b) City or town Perryville
(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 Mo (b) County Perry

(c) City or town Perryville
(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 Ferd L. Schindler

3. (b) If veteran, name war _____

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11th
year 1942 hour 12:45 minute _____ P. M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, Divorced Widowed

6. (b) Name of husband or wife Rose Unwerferth alive _____ years

6. (c) Age of husband or wife if _____

7. Birth date of deceased November 14, 1856
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 1, 1942, to Nov. 11, 1942
that I last saw him alive on Nov. 11, 1942
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

85 11 27 hr. min.

Immediate cause of death Hypostatic Pneumonia

Due to apoplectic stroke

9. Birthplace Perry County Mo. U
(City, town, or county) (State or foreign country)

Due to _____

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

10. Usual occupation Retired farmer

11. Industry or business _____

Major findings: Of operations None

Of autopsy None

12. Name Raymond Schindler

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

14. Maiden name Catherine Sutterer

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. David Deig

(b) Address Perryville, Mo.

17. (a) Burial (b) Date thereof Nov 19, 1942
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Rev. Ernest Horn

(b) Address Perryville Mo.

19. (a) 11/12/42 (b) O. J. Preusse
(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)

(c) Means of injury D

23. Signature Dr. S. E. Pedersen (M. D. or other)

Address Perryville, Mo. Date signed 11.12.42

1110

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 3
District File Number 1242-1471
Date Filed 12-8-42

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

Albert Bey

Licensed Embalmer No.

3866

P. O. Address

Perryville, Md

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. 27753
Registrar's No. 70

Registration District No. 273

Primary Registration District No. 5910-

1. PLACE OF DEATH:

(a) County Perry
(b) City or town Perryville
(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 Fred L. Schneider
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color of 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 Nov 14
(Month) (Day) (Year)

8. AGE: Years 85 Months _____ Days _____ If less than one day _____ min.

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

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) _____ (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I first saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia Duration _____

Due to apoplexy stroke

Due to This old man just lay on back until lungs failed. Hypostatic pneumonia

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 Dr. B. E. Peden (M. D. or other) _____
Address 1122 North Perryville Date signed 10/9/41

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

SUPPLEMENTARY

