No. 2
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17-39
X26390

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. 17429

FILED JUN 2 1943 42

Registration District No. 1000

Primary Registration District No. 1000

Registrar's No. 536

1. PLACE OF DEATH:

(a) County BUCHANAN

(b) City or town ST. JOSEPH (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital # 2. 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days (Specify whether

In this community Same. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County ~~Buchanan~~ DeKalb

(c) City or town ~~St Joseph~~ Westerly (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William H. Schlup.

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex M O

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs

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

7. Birth date of deceased 8 (Month) 1 (Day) 1855 (Year)

8. AGE: Years 87 Months 8 Days 28 If less than one day hr. min.

9. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Same

FATHER
12. Name Unknown
13. Birthplace (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) 9 (State or foreign country)

16. (a) Informant Records

(b) Address State Hospital

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/28-43 (Month) (Day) (Year)

(c) Place: burial or cremation Westerly Mo

18. (a) Signature of funeral director Bucher Funeral Home

(b) Address Maysville Mo

19. (a) 4-28-43 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 28 year 1943 hour 3 minute P M.

21. I hereby certify that I attended the deceased from 4/21/43, 19 to 4/28/43, 19; that I last saw him alive on 4/28/43, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	3 da
Due to Senility	
Due to Arteriosclerosis	
Other conditions Psychotic (Include pregnancy within 3 months of death)	10 y

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)

(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 —

23. Signature L H Dunham MD (M.D. or other)

Address State Hospital #2 Date signed 4/28/43

1233 (Licensed Embalmer's Statement on Reverse Side) St Joseph, Mo

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. 2960

P. O. Address Maywell Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.