

No. 2
-2-43
17-39
1-2-43

AUG 5 1943 42

Registration District No. _____ Primary Registration District No. 40-50-3134 Registrar's No. 706

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town Industrial City - Waverly
(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 Missouri (b) County Buchanan
(c) City or town Industrial City
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes-No)
If yes, name country _____

3. (a) PRINT FULL NAME Catherine Schiltz.

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife John Schiltz. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 14 1855
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
88 1 12 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Nicholas Diedrich
13. Birthplace Luxenburg Germany
(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 James T. Schiltz
(b) Address Industrial City

17. (a) Burial (b) Date thereof June 29, 43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Herwald S. Sidergren
(b) Address 1802 Union St. Joseph, Mo.

19. (a) 6-28-43 (b) Rose Heizinger
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 26th day June
year 1943 hour 12: minute 55 A.M.

21. I hereby certify that I attended the deceased from June 21, 1943, to June 26, 1943
that I last saw her alive on June 26, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death pneumonia chronic pyelociditis

Due to _____
Due to _____
Other conditions ✓
(Include pregnancy within 3 months of death)

Major findings: Of operations ✓
Of autopsy ✓

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 _____

23. Signature Colin Ramsey (M. D. or other)
Address Postoffice 215 Date signed June 26-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 *John L. Lurley*.....

Licensed Embalmer No. *4050*.....

P. O. Address *St Joseph MS*.....

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.

Registration District No. 42 Primary Registration District No. 5124 Registrar's No. 706

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town Washington
(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 _____ (Specify whether _____)
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 Catherine Schilz
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July 1943 year _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I have seen him _____ and that death occurred on the date and hour stated above. _____
Immediate cause of death: pneumonia Duration _____
chronic myocarditis

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 14 (Month) (Day) (Year)

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

8. AGE: Years 88 Months 1 Days _____ If less than one day _____ min.
9. Birthplace Iowa (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? _____

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____ (City, town, or county) (State or foreign country)
15. Birthplace _____ (City, town, or county) (State or foreign country)

23. Signature Collis Roundy (M. D. number) _____
Address St. Joseph, Mo. Date signed _____

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-24441