

No. 1
9-4-41
17-39
X25484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 15 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

34515

Registration District No. 80 Primary Registration District No. 3017 State File No. _____ Registrar's No. 137

1. PLACE OF DEATH:
(a) County Cooper
(b) City or town Boonville
(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 6 Months (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(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 0---

3. (a) PRINT FULL NAME Mrs. Ottilia Schreiner.
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 27
year 1943 hour 11 minute P. M.
21. I hereby certify that I attended the deceased from April
1943 to Oct 27 1943
that I last saw her alive on Oct 27 1943
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Adam Schreiner.
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 6th 1887
(Month) (Day) (Year)

Immediate cause of death Exhaustion Duration _____
Due to Nephritis ✓
Due to _____

8. AGE: Years Months Days If less than one day
76 3 21 hr. _____ min.
9. Birthplace Boonville, Missouri.
(City, town, or county) (State or foreign country)

Other conditions Seizure
(Include pregnancy within 3 months of death)
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation Housewife.
11. Industry or business At home.
12. Name Christian Schack.
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Philippina Heas
15. Birthplace Germany
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy _____

16. (a) Informant Mrs. Paul Jaeger.
(b) Address Boonville, Mo.
17. (a) Burial (b) Date thereof Oct. 29th/43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Walnut Grove Cem.
18. (a) Signature of funeral director Woodman & Holley
(b) Address Boonville, Mo.
19. (a) 10-29-43 (b) Dr Chas. Swap.
(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) No
(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 M.S. McGuire (M. D. or other) M.D.
Address Boonville Mo Date signed 10/27/43

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

MOTHER FATHER

1048

RECEIVED

11-3-43

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.....

J. H. Goodman

Licensed Embalmer No. 1178

P. O. Address Roanville, W. Va.

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. 2

Primary Registration District No. 3017

Registrar's No. 137

1. PLACE OF DEATH:

(a) County Cooper
 (b) City or town Boonville
(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)

3. (a) PRINT FULL NAME Mrs Othilia Schreiner

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

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

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

7. Birth date of deceased July 6 1906
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days _____
If less than one day, _____ min.

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

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)

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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above and the immediate cause of death exhaustion

Due to nephritis
chronic interstitial

Other conditions sinusitis
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy 131a

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 M. S. McGuire (M. D. or other) _____
 Address Boonville, Mo. Date signed _____

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

SUPPLEMENTARY

34515