

FILED DEC 11 1943

Registration District No. ~~128~~ 128

Primary Registration District No. ~~2000~~ 2000

State File No. _____
Registrar's No. 953

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

6

1. PLACE OF DEATH: **GREENE**

(a) County **GREENE**

(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. John's Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **6 Days**
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: **114**

(a) State: **MISSOURI** (b) County: **Wright**

(c) City or town: **Mansfield**
(If outside city or town limits, write "RURAL")

(d) Street No.: **114** **HOSPITAL**
(If rural, give location)

(e) If foreign born, how long in U. S. A. **1** years.

3. (a) PRINT FULL NAME **ORRA J. SCHMACHTENBERGER**

3. (b) If veteran, name war: **NONE**

3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV.** day **25**
year **1943** hour **1** minute **05 P.** M.

4. Sex **MALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **HELETTA SCHMACHTENBERGER**

6. (c) Age of husband or wife if **59** years

7. Birth date of deceased: **JAN 1 1879**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Nov 19, 1943 to 11-25, 1943**
that I last saw him alive on **Nov 24, 1943**
and that death occurred on the date and hour stated above.

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

64 10 24 hr. min.

Immediate cause of death **Uraemia**
Septicemia of
plutal glomerulonephritis

Due to _____

Due to **1370**

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

10. Usual occupation **FARMER - RETIRED**

11. Industry or business _____

Other conditions **Entered hospital**
(Include pregnancy within 3 months of death)

Major findings: **acute h.p.n. 18545-110**

Of operations **super pubic**

Of autopsy **Capitulum was done**

Duration _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name **JERIAH SCHMACHTENBERGER**

13. Birthplace **NOT KNOWN**
(City, town, or county) (State or foreign country)

14. Maiden name **RACHEL DAVIDSON**

15. Birthplace **NOT KNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **Luetta Schmachtenberger**

(b) Address **MANSFIELD MO**

17. (a) **BURIAL** (b) Date thereof **NOV 28 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MANSFIELD MO**

18. (a) Signature of funeral director **J. A. Steffen**

(b) Address **MANSFIELD MO**

19. (a) **11-27-43** (b) **Orme Landry**
(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)

(a) Means of injury _____

23. Signature **J. H. Steffell** (M. D. or other) **mb**

Address **Springfield** Date signed **11-26-43**

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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.....

F. C. Staffe

Licensed Embalmer No. *3221*

P. O. Address *Manfield, Mo*

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.