

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 210

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Stone Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether years, months or days) 25 years

8. (a) PRINT FULL NAME Fred A. Schad

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M 1

6. (b) Name of husband or wife Clara C. Galloway Schad 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased 2 4 1871
(Month) (Day) (Year)

8. AGE: Year 71 Months 9 Days 2 If less than one day hr. min.

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

10. Usual occupation Carpenter

11. Industry or business Unknown

12. Name Unknown 18. Birthplace " " 4
(City, town, or county) (State or foreign country)

14. Maiden name Unknown 15. Birthplace " " 4
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clara C. Schad

(b) Address Carl Junction, Mo.

17. (a) Burial, entombment, or removal Burial (b) Date thereof 11 9 43
(Month) (Day) (Year)

(c) Place: burial or cremation Carl Junction Cemetery

18. (a) Signature of funeral director Remy Funeral Service
(b) Address Carl Junction Mo

19. (a) 700 9 43 (b) Elizabeth Couplan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Carl Junction Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 602 Locust
(If rural, give location)
(e) If foreign born, how long in U. S. A? 1 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Nov day 6
year 1943 hour 10:31 minutes 12 AM

21. I hereby certify that I attended the deceased from Nov 30, 1943, to Nov 6, 1943, and that death occurred on the date and hour stated above

that I last saw him live on Nov-6, 1943
Immediate cause of death Medullary Paralysis Duration 2 hrs

Due to Carcinoma of sigmoid

Due to _____

Other conditions (Include pregnancy within 3 months of death) H6e

Major findings: Of operations Same as above

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) (e) Means of injury _____

23. Signature Albert B. Wheeler M.D. or other
Address Carthage Mo Date signed Nov 8

PHYSICIAN
Underline the cause to which death should be charged statistically

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

Rev. 6-17-39 I X1951

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

43-11-994

AUG 13 1944

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. M. Jones*

Licensed Embalmer No. *2319*

P. O. Address..... *Joplin 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, above space should be left blank.