

No. 2  
-5-42  
-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42068**  
Registrar's No. **270**

FILED DEC 28 1949  
Registration District No. \_\_\_\_\_

Primary Registration District No. **3016**

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

1. PLACE OF DEATH:  
(a) County **Cole**  
(b) City or town **Jefferson City**  
(c) Name of hospital or institution: **703 Jackson Jefferson St.**  
(d) Length of stay: **40 yrs.**  
In this community **40 yrs.**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Cole**  
(c) City or town **Jefferson City**  
(d) Street No. **703 Jackson**  
(e) Citizen of foreign country? **No.**

3. (a) PRINT FULL NAME **Peter Joseph Schell**  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Dec** day **14**  
year **1949** hour \_\_\_\_\_ minute **11 9** M.  
21. I hereby certify that I attended the deceased from **no attendance**  
that I last saw him alive on \_\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **Wh**  
6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Monika**  
6. (c) Age of husband or wife if alive **42** years  
7. Birth date of deceased **April 13 1880**

Immediate cause of death **Heart Disease**  
Due to **Senility**

8. AGE: Years **63** Months **8** Days **1**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace **St. Thomas Mo**  
10. Usual occupation **Musician & Owner of Music Store**  
11. Industry or business \_\_\_\_\_  
12. Name **Simon Schell**  
13. Birthplace **Germany**  
14. Maiden name **Unknown**  
15. Birthplace \_\_\_\_\_

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? \_\_\_\_\_  
(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 **Edw Murray** (M. D. or other) \_\_\_\_\_  
Address **Jefferson City Mo** Date signed **12-17-49**

16. (a) Informant **Mrs. Monika Schell**  
(b) Address **703 Jackson**  
17. (a) **Burial** (b) Date thereof **12-17-49**  
(c) Place: burial or cremation **Recreation**  
18. (a) Signature of funeral director **James Swain**  
(b) Address **702 Jefferson**  
19. (a) **12-19-49** (b) **Thermal Richter**

**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 *A. Anderson*  
Licensed Embalmer No. *3641*  
P. O. Address *Dumas*

**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. 17

Primary Registration District No. 3016

Registrar's No. 270

1. PLACE OF DEATH:

(a) County Cole  
(b) City or town Jefferson city  
(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)

3. (a) PRINT FULL NAME Peter Joseph Schell

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

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 April 18 1888  
(Month) (Day) (Year)

8. AGE: Years 63 Months \_\_\_\_\_ Days \_\_\_\_\_ (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 \_\_\_\_\_ (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 \_\_\_\_\_ year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death Heart Disease Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to Senility 71. M. O.

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

5-42068