7. S. No. 2
DM—9-4-41
ev. 5-17-39
P I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

6631

State File No.

FILED MAR 15 1942

Registration District No. 1942 — Primary Registration District No. 1000 — Registrar's No. 232

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 2 St Joseph Mo (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 4 yrs 0 mo 21 days (Specify whether years, months or days)
In this community: yes

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Lafayette
(c) City or town: Corder Mo (If outside city or town limits, write "RURAL")
(d) Street No.: Rural (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Henry H Schoeperkoetter
3. (b) If veteran, name war: Nil
3. (c) Social Security No.:
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: June (Month) 17 (Day) 1875 (Year)

8. AGE: Years	Months	Days	If less than one day
69	8	3	hr. min.

9. Birthplace: Cassonade Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation: none
11. Industry or business:
FATHER 12. Name: Unknown
FATHER 13. Birthplace: (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: (City, town, or county) (State or foreign country)
16. (a) Informant: Hospital No 2 records
(b) Address: St Joseph Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-21-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Corder Mo
18. (a) Signature of funeral director: Aeroxt Koeler
(b) Address: Higginsville Mo
19. (a) 2-21-44 (Date received local registrar) (b) Rae Hezzy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: 20th day: Feb year: 1944 hour: 2 minute: 30 P.M.
21. I hereby certify that I attended the ~~deceased~~ from: Officer of the day 6 to 6 pm
that I last saw him alive on: Feb 18 1944
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hemiplegia	1 wk
of the brain	
Due to arteriosclerosis	
cerebral since	1940
Due to advanced age	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 130
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): None
(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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: C.H. Dunbar MD by E E Rosenes MD (M.D. or other)
Address: State Hospital No 2 Date signed: 2/20/1944 St Joseph Mo

1233 (Licensed Embalmer's Statement on Reverse Side)

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 Delbert Hoefer

Licensed Embalmer No. 539

P. O. Address Higginsville 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.