

FILED MAY 11 1944
Registration District No. 1012

Primary Registration District No. 40041

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town Bolckow
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 80 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
(c) City or town Bolckow
(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 _____

3. (a) PRINT FULL NAME Cathrine Schildknecht

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 W

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

7. Birth date of deceased MAY 26 - 1862
(Month) (Day) (Year)

8. AGE: Years 91 Months 11 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Andinopolis Ind 1
(City, town, or county) (State or foreign country)

10. Usual occupation AT Home

11. Industry or business _____

12. Name UNKNOWN

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

14. Maiden name JULIA UNKNOWN

15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant Leah Schildknecht

(b) Address Bolckow Ind

17. (a) BURIAL (b) Date thereof 4-27-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bolckow

18. (a) Signature of funeral director L. E. Breit

(b) Address Lovannah Ind

19. (a) 4-25-44 (b) J.H. Entelman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 25 -
year 1944 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from 4-7
1944, 19... to 4-25, 1944
that I last saw her alive on 4-25 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____

Due to _____

Other conditions: JZa
(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? _____

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

23. Signature W. Logan (M. D. or other) _____
Address Bolckow Ind Date signed 4-26-44

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

200

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..... *E. C. Breit*

Licensed Embalmer No. *2650*

P. O. Address *Savannah 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.