

FILED MAY 14 1944
Registration District No. _____

Primary Registration District No. 1020

Registrar's No. 406

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Rosary Hill Nursing Home. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 1 Year.
(Specify whether years, months or days)
In this community 2 Years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Buchanan. //
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 615 E. Kansas Avenue. 7
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country. 0

3. (a) PRINT FULL NAME

Mary Schlagman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female. 5. Color or race White. 6. (a) Single, widowed, married, divorced, or widowed.

6. (b) Name of husband or wife Frank Schlagman. 6. (c) Age of husband or wife if alive, years

7. Birth date of deceased April 20, 1854
(Month) (Day) (Year)

8. AGE: Years 90 Months 0 Days 10 If less than one day hr. min.

9. Birthplace Milwaukee Wisconsin.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife.

11. Industry or business

MOTHER FATHER

12. Name John Schlagman.

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

14. Maiden name Theresa Schummer.
15. Birthplace Germany.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs A. J. Dryer.

(b) Address 615 E. Kansas Ave.

17. (a) Removal. (b) Date thereof April 30, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grand Island, Nebr.

18. (a) Signature of funeral director *Meruauil W. Sidonfaden*

(b) Address 1802 Union St. St. Joseph Mo.

19. (a) 4/30/44 (b) *Rose Heitzog*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1944 hour 10:30 minute A. M.

21. I hereby certify that I attended the deceased from
OV. 10 1943 to April 29, 1944;
that I last saw her alive on April 29, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death
Myocardial degeneration 6 wks.
Senile Dementia 18 mos.

Due to
Due to Luets

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations --

Of autopsy: 2

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 6

23. *Charles W. Werner* (M. D. or other)
Address 221 Kirkpatrick Bldg. Date signed 4/30/
St. Joseph, Mo. 1944

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

NOV 6 1946

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..... *Robert H. Reed*

Licensed Embalmer No. *3745*

P. O. Address *St Joseph 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.