

FILED MAY 10 1944
Registration District No. **275**

Primary Registration District No. **3053**

Registrar's No. **54**

1. PLACE OF DEATH:

(a) County **Phelps**
(b) City or town **Rolla**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Nelle McFarland Memorial Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 days** (Specify whether
In this community **yes** years, months or days)

3. (a) PRINT FULL NAME **John Schoneis**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **No** 6. (c) Age of husband or wife If alive **years**
7. Birth date of deceased **1865**
(Month) (Day) (Year)

8. AGE: Years **79** Months Days If less than one day **hr. min.**

9. Birthplace **January 7**
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business
12. Name **Unknown**
13. Birthplace **9**
(City, town, or county) (State or foreign country)
14. Maiden name **9**
15. Birthplace **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **W. J. Brown**
(b) Address **Leasburg Mo.**

17. (a) **Burial** (b) Date thereof **4-12-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Leasburg Mo.**

18. (a) Signature of funeral director **Robert G. Grogg**
(b) Address **Rolla Mo.**

19. (a) **4/12/1944** (b) **John Schoneis**
(Date of registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Crawford**
(c) City or town **Leasburg** (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **12**
year **1944** hour **7** minute **M.**

21. I hereby certify that I attended the deceased from **4-3-44** 19 to **4-12-44** 19
that I last saw him alive on **April 12, 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Interstitial Nephritis** Duration

Contributing cause: **Due to Ravages of old age**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: **131a**
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 **John Schoneis** (M. D. or other)
Address **Rolla, Mo.** Date signed **4/12/44**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A CERTIFICATE

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 *Albert E. Long*
Licensed Embalmer No. *3504*
P. O. Address *Douglas 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 54

Registration District No. 275 Primary Registration District No. 3053

1. PLACE OF DEATH:
(a) County Polk
(b) City or town Rolla
(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)

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.....

3. (a) PRINT FULL NAME John Schoneis
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April 1942 year 1942 minute..... M.
21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... Year.....
7. Birth date of deceased..... (Month) (Day) (Year)

Due to.....
Due to.....
Other conditions..... (include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....

8. AGE: Years 79 Months..... Days..... If less than one day..... min.
9. Birthplace..... (City, town, or county) (State or foreign country) Germany

10. Usual occupation He was a Rail Road Tie Inspector at Leaning, Mo.
11. Industry of business.....
12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name..... (City, town, or county) (State or foreign country)
15. Birthplace..... (City, town, or county) (State or foreign country)

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.....

16. (a) Informant.....
(b) Address.....
17. (a) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....
18. (a) Signature of funeral director.....
(b) Address.....
19. (a)..... (b) John Schoneis (Registrar's signature)
(Date received local registrar)..... (Registrar's signature)

23. Signature..... (M. D. or other).....
Address..... Date signed.....

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

MOTHER FATHER

maternal

SUPPLEMENTAL

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

15470