

MAY 8 1944

Registration District No. **305**

Primary Registration District No. **6047**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County **St Charles**
(b) City or town **Silverson**
(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 **28 yrs** years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **St Charles**
(c) City or town _____ (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 _____

3. (a) PRINT FULL NAME **Threse Mary Schramm**

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 **Widowed**

6. (b) Name of husband or wife **Anton Schramm** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 30 1869**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	74	8	7	hr. min.

9. Birthplace **Silverson Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Home duties**

11. Industry or business _____

12. Name **Frank Wilcox**

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

14. Maiden name **Mary Bruteiman**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Josephine Schramm**
(b) Address **Wentzville Mo**

17. (a) **Burial** (b) Date thereof **April 10-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Josephine Mo**

18. (a) Signature of funeral director **T. J. ...**
(b) Address **Wentzville Mo**

19. (a) **4-12-44** (b) **Margaret S. Forstner**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **6**
year **1944** hour **7** minute **4** A. M.

21. I hereby certify that I attended the deceased from **June 1938** to **April 6 1944**
that I last saw her alive on **April 5 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Carcinoma Stomach** Duration **6 mo.**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **H6P**

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

23. Signature **Nicholas J. Kouch** (M. D.)
O. Fallon Mo Date signed **4/9/44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 5-5-44

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 _____

T. P. Stewart

Licensed Embalmer No. 2711

P. O. Address Wentzville, 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.

2B
13
36930

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. _____

Registration District No. 305

Primary Registration District No. 6047

1. PLACE OF DEATH:

(a) County St Charles
 (b) City or town Helmire
 (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 28 yrs (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Charles
 (c) City Helmire (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 Theresa M. Schramm
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1948 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

4. Sex F 5. Color or race W
 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: July 30 (Month) (Day) (Year)
 8. AGE: Years 74 Months 8 Days _____ If less than one day _____ min.
 9. Birthplace: _____ (City, town, or county) (State or foreign country) Mo.
 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)

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

16. (a) Informant _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)
 (c) Place: burial or cremation _____

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 _____

18. (a) Signature of funeral director _____
 (b) Address _____
 19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

SUPPLEMENTAL

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

MOTHER FATHER

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

15648

Handwritten text, possibly a name or title, written in cursive.

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