V. S. No. 2
50M—5-42
Rev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 30 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18654

Registration District No. 2 0 1

Primary Registration District No. 3043

Registrar's No. 149

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: I702 Collier St. 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 About 7 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 64

(a) State Missouri (b) County Marion 3

(c) City or town Hannibal Mo. 4
(If outside city or town limits, write "RURAL")

(d) Street No. I702 Collier St.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Marie Schaich

3. (b) If veteran, name war XXXX XXXX XXX

3. (c) Social Security No.

4. Sex Female

5. Color or race White 1

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ 2

6. (b) Name of husband or wife Fred Schaich

6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased 3 (Month) 3 (Day) I859 (Year)

8. AGE: Years 85 Months I Days I5 If less than one day hr. min.

9. Birthplace Lorane France (City, town, or county) 5 (State or foreign country)

10. Usual occupation House Wife

11. Industry or business XXXXXXXX XX

FATHER
12. Name Jacob Losson
13. Birthplace ~~France~~ Forren (City, town, or county) ~~Forren~~ France 5 (State or foreign country)

MOTHER
14. Maiden name Hanna Decker
15. Birthplace ~~France~~ Forren (City, town, or county) ~~Forren~~ France 5 (State or foreign country)

16. (a) Informant Hildagard Schaich

(b) Address I702 Collier St. Hannibal Mo.

17. (a) Palmyra Mo. (Burial, cremation, or removal) (b) Date thereof 4-I8-I944 (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph Cemetary

18. (a) Signature of funeral director A. M. Sprague

(b) Address Palmyra Mo.

19. (a) 5/1/44 (Date received local registrar) (b) N W Connor (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. Apr. day I8
year I944 hour 8 minute OI AM.

21. I hereby certify that I attended the deceased from June, 1943, to Apr 18, 1944
that I last saw her alive on Apr 16, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-vascular - Renal Disease

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

13/a

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 [signature] (M. D. or ~~other~~)

Address Hannibal Mo. Date signed Apr 24-44

1141

(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 R. M. Sprague

Licensed Embalmer No. 999

P. O. Address Palmyra 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.