

FILED JUN 12 1944

Registration District No. 23.5Primary Registration District No. 6118

Registrar's No. _____

1. PLACE OF DEATH

(a) County Death
 (b) City or town Commerce R.F.D. 5 miles S.W. of
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: NONE
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution NONE
 (Specify whether _____)
 In this community WIFE
 years, months or days

3. (a) PRINT FULL NAME CLEMENTINE SCHERER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEM 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife SCHERER 6. (c) Age of husband or wife if alive 56 years
 7. Birth date of deceased MAR 7 1890
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 2 15 hr. _____ min.

9. Birthplace NEAR KELSO MISSOURI
(City, town, or county) (State or foreign country)10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER { 12. Name FLORIAN RESSEL
 13. Birthplace AUSTRIA LL
 (City, town, or county) (State or foreign country)
 14. Maiden name MARY MORBER
 15. Birthplace SCOTT COUNTY MO
 (City, town, or county) (State or foreign country)

16. (a) Informant LAWRENCE SCHERER
 (b) Address COMMERCE Mo R.F.D.
 17. (a) BURIAL (b) Date thereof MAY 25-44
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation KELSO CATHOLIC CEM

18. (a) Signature of funeral director Heisserer Funeral Home
 (b) Address Oran Missouri
 19. (a) 6/3/44 (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County SCOTT
 (c) City or town COMMERCE R.F.D.
 (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 22ND
 year 1944 hour 10.30 minute P. M.
 21. I hereby certify that I attended the deceased from May 22
 _____, 1944 to May 22, 1944
 that I last saw her alive on May 22, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Stomach

Due to _____

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

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?
 _____ (Specify type of place)

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature M P Hogan (M.D. or other) DO
 Address Benton Mo Date signed 5-23-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

6-8-4

RECEIVED

District Health Office No.

District File Number 674-81

Date Filed 6-8-4

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
43
36930

State File No. June

Registration District No. 335

Primary Registration District No. 6118

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Pruitt, Sylvan, Mo.
(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 _____
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 Clementine Scherer

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 M

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

7. Birth date of deceased March 7
(Month) (Day) (Year)

8. AGE: Years 54 Months 2 Days 10 If less than one day, _____ min.

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

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)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Year 1944 Hour _____ 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 _____

Due to _____

Due to _____

Other conditions _____
(include pregnancy within 3 months of death)

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

19203