

5132

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 28 1944
Registration District No. 42

Primary Registration District No. 5135

Registrar's No. 250

1. PLACE OF DEATH: Bethel
 (a) County: Bethel
 (b) City or town: Quinn mo. R.H. 1
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Strom Ash Hill Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
 (Specify whether _____)
 In this community: Strom
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State: MO (b) County: Bethel
 (c) City or town: Quinn - Road
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? 0 years

3. (a) PRINT FULL NAME: LOWELL D. D. SCHRADER
 3. (b) If veteran, L name war _____
 3. (c) Social Security No. L

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 27
 year 1944 hour 1 minute 45 P. M.

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

21. I hereby certify that I attended the deceased from July 22
1944, to July 27, 1944
 that I last saw him alive on July 22, 1944
 and that death occurred on the date and hour stated above.

7. Birth date of deceased: July 16 - 1944
 (Month) (Day) (Year)
 8. AGE: Years _____ Months 11 If less than one day
 hr. _____ min. _____

Immediate cause of death: Melanomatosis, granular
birth, would not
 Due to: take measurement
 Due to: _____

9. Birthplace: Quinn - mo
 (City, town, or county) (State or foreign country)
 10. Usual occupation: _____

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

11. Industry or business: _____
 12. Name: Carl Schrader
 13. Birthplace: mo
 (City, town, or county) (State or foreign country)
 14. Maiden name: Serrah N. Schrader
 15. Birthplace: mo
 (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's own signature: Carl Schrader
 (b) Address: Quinn mo
 17. (a) Burial (b) Date thereof: July 28 1944
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation: New Hope
 18. (a) Signature of funeral director: family
 (b) Address: _____
 19. (a) 7-27-44 (b) Belle Turner
 (Date received local registrar) (Registrar's signature)

23. Signature: Scott Cooper (M. D. or other) _____
 Address: Quinn - mo Date signed: 7/28/44

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MARGIN RESERVED FOR BINDING

Rev. 5-17-39
U.S. GPO: 1939 O X 1931

RECEIVED

District Health Office No. 2,

District File Number 844-997

Date Filed 8-3-44

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.