

24233

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 8 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 42

Primary Registration District No. 5135

Registrar's No. 251

1. PLACE OF DEATH:

(a) County Butler

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

(c) Name of hospital or institution Home 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 Home _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Butler 12

(c) City or town Quincy Rural
(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 PEARL GENE SCHRADER

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased July 16 1944
Month (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>11</u>	hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Carl Schrader

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

14. Maiden name Sarah Dolly

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

16. (a) Informant's own signature Carl Schrader

(b) Address Quincy - R.R. - 1

17. (a) New Hope (b) Date thereof July 26-44
(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 Kierne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1944 hour 1 minute 30 P M.

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

Immediate cause of death Malnutrition, probably
birth, would not take
Due to malnutrition

Due to _____
Other conditions SA
(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) Means of injury _____

23. Signature Scott Cook (M. D. or other) _____
Address Quincy MO Date signed 7/28/44

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

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.

FORM 5-17-39 Rev. 5-17-39

RECEIVED

District Health Office No. 2,

District File Number 844-996

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.