

FILED JUL 29 1944

Registration District No. 1

Primary Registration District No. 3016

Registrar's No. 169

1. PLACE OF DEATH:

(a) County Osage
(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St Mary's Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 4 weeks
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ronna Maer Schulte

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 infant

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

7. Birth date of deceased Sept 24 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
9 28 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Fred Schulte

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

14. Maiden name Leona Schwartz

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

16. (a) Informant Mrs Fred Schulte

(b) Address Freeburg Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 -24- 44
(Month) (Day) (Year)

(c) Place: burial or cremation Freeburg Mo

18. (a) Signature of funeral director Clyde Morton

(b) Address Freeburg Mo

19. (a) July 23 1944 (b) Norma Richter
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Osage 76
(c) City or town Freeburg Mo. R.D. 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22
year 1944 hour 6 minute 10 P M.

21. I hereby certify that I attended the deceased from July 20
July 22 1944 to July 26
19 44
that I last saw him alive on July 22 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myocardial

Due to _____
for Congenital defect

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

Major findings: 157e
Of operations _____
Of autopsy _____

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

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 Mr R. C. Adred (M. D. or other) _____
Address Freeburg Mo Date signed 7/22/44

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

654

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-27-44

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 *Not Embalmed*.....

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, fact should be so stated above.