

S. No. 2
OM-5-43
v. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35171**

Registration District No. **5194A**

Primary Registration District No. **3060**

Registrar's No. **195**

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington
(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) 1

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME JOHANNA M. SCHMIDT

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Daniel W. Schmidt

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

7. Birth date of deceased April 9 1873
(Month) (Day) (Year)

8. AGE: Years 71 Months 6 Days 8

If less than one day _____ hr. _____ min.

9. Birthplace Jefferson Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Federick Williams

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

14. Maiden name Sarah E. Brown

15. Birthplace York Pa MO
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Charles Yeager

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof Oct 19, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 2007 Cem. Oak Run Mo

18. (a) Signature of funeral director Miller Funeral Home

(b) Address Farmington, Mo.

19. (a) Oct 19 1944 (b) Dorcas Bohan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Farmington
(If outside city or town limits, write "RURAL")

(d) Street No. 311 South Main
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17 year 1944 hour 11 minute 00 A.M.

21. I hereby certify that I attended the deceased from Jan. 1940, to Oct. 17 1944

that I last saw her alive on Oct. 14 1944

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy -

Due to Arteriosclerosis & Hypertension

Due to _____

Duration

1 hr.

6 yrs.

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

Major findings: _____

Of operations _____

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? _____

23. Signature Geo. H. Watters (M. D. or other) _____

Address Farmington Mo. Date signed 10-19-44

1373

(Licensed Embalmer's Statement on Reverse Side)

142
4-44

RECEIVED

District Health Officer No. 4

District File Number 1144-4474

Date Filed 11-3-44

NOV 9 1944

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 *Bert J. Miller*

Licensed Embalmer No. *3752*

P. O. Address *Farmington, 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.