

No. 2
— 8-43
5-17-39
X37823

37011

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 94

FILED DEC 13 1944
Register of Deaths No. 137944

Primary Registration District No. 5016

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

1. PLACE OF DEATH:
 (a) County Andrew
 (b) City or town Monroe Twp
(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 56 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Andrew 2
 (c) City or town Monroe Township
(If outside city or town limits, write "RURAL") 0
 (d) Street No. _____
(If rural, give location) 0
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ 1

3. (a) PRINT FULL NAME Bessie Schenk
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex <u>F</u>	5. Color or race <u>W</u>	6. (a) Single, widowed, married, divorced <u>M</u>
6. (b) Name of husband or wife <u>Otto Schenk</u>	6. (c) Age of husband or wife if alive <u>53</u> years	
7. Birth date of deceased <u>Oct 26 1889</u>	<small>(Month)</small>	<small>(Day)</small> <small>(Year)</small>

8. AGE: Years <u>55</u>	Months <u>0</u>	Days <u>13</u>	If less than one day ____ hr. _____ min.
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9. Birthplace Andrew Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER
 12. Name William Triplett
 13. Birthplace Harmony Ind
(City, town, or county) (State or foreign country)
 14. Maiden name Tina Breit
 15. Birthplace AMAZONIA Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Otto Schenk
 (b) Address Gosby Mo.

17. (a) B. (b) Date thereof 11-12-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SAVANNAH Mo

18. (a) Signature of funeral director E.C. Breit

(b) Address Savannah Mo

19. (a) 11-10-44 (b) J.H. Fitchman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 9
 year 1945 hour 2 minute 45 P.M.
 21. I hereby certify that I attended the deceased from December 10 1940 to Nov 9 1944
 and that death occurred on the date and hour stated above. 11-9-1944

Immediate cause of death Cerebral Hemorrhage
 Due to Diabetes + nephritis

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 0

23. Signature E.M. Reynolds (M. D. or other)

Address Union Star Mo Date signed 11-9-44

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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

FEB 1 0 1953

FEB 6 1953

FEB 6 1953

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah 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.

Registration District No. 2 Primary Registration District No. 5016

1. PLACE OF DEATH:
(a) County Andrew
(b) City or town Monroe Sup.
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Bessie Schenk
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: Oct 26 (Month) (Day) (Year)

8. AGE: Years 55 Months 0 Days 5 (If less than one day, in _____ min.)

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

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 12 day 20 year 19 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 _____

Duration _____
Chronic Hypertension

Due to _____
Due to _____ 12/20

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

Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

1944
S-37011