

3. No. 2
1-8-43
5-17-39
1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40926

FILED JAN 5 1945
72

State File No. _____

Registration District No. _____

Primary Registration District No. 5289

Registrar's No. 123

1. PLACE OF DEATH:

(a) County Clay
(b) City or town No. K.E. Mo. Rural Ballastine
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 10 years, months or days yes

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay 24
(c) City or town No. K.E. Mo. Rural 70
(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 _____

3. (a) PRINT FULL NAME

SARAH SCHINKE

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife Carl August Schinke

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

7. Birth date of deceased June (Month)

9 (Day) 1857 (Year)

8. AGE:

Years 87 Months 6 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace

Trier Prussia (City, town, or county) X (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name

Hass 8

13. Birthplace

Trier Prussia (City, town, or county) (State or foreign country) 8

14. Maiden name

Baeh 9

15. Birthplace

unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant

Norma Schinke 1

(b) Address

No. K.E. Mo. RP #10

17. (a)

Burial (b) Date thereof 12-22-'44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

Highland Park

18. (a) Signature of funeral director

Walter Funeral Home

(b) Address

No. K.E. Mo

19. (a)

Dec 20 1944 (Date received local registrar) (b) Rich N. Henry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19
year 1944 hour 12 minute 2007 M.

21. I hereby certify that I attended the deceased from 11-1-42
to 12-15-44

that I last saw h. Ev alive on 12-15 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion ?

Due to Arteriosclerosis

Due to chronic myocarditis

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

Major findings: _____
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 MO

23. Signature R. H. ... (M. D. or other) _____

Address North K.E. Mo Date signed 12/21/44

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-4-58

AUG 22 1956

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

Jack W. Laybourn

Licensed Embalmer No.

1716

P. O. Address

R. E. Mc

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. 72

Primary Registration District No. 5289

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

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Prue (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 _____ years, months or days

3. (a) PRINT FULL NAME Sarah Schunk

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 _____

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

7. Birth date of deceased: June 9 (Month) (Day) (Year)

8. AGE: Years 87 Months 6 Days _____ If less than one day, _____ min.

9. Birthplace Prue, Missouri (City, town, or county) (State of foreign country)

10. Usual occupation Retired

11. Industry or business Housewife

MOTHER FATHER

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Rich N. Henry (Date received local registrar) (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 _____ year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

40946