

S. No. 2
M-8-43
5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2458
Registrar's No. 3

Registration District No. 146

Primary Registration District No. 5568

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Rural - Blue Turn
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Emory and August
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Rural Blue 0
(If outside city or town limits, write "RURAL")
(d) Street No. Emory and August 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 11

3. (a) PRINT FULL NAME Goldie S. Schreyer
3. (b) If veteran, name war.....
3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. 11
Year 1945 hour 6 minute 12 P.M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John C. Schreyer
6. (c) Age of husband or wife if alive 9 years
7. Birth date of deceased March 9, 1890
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 14, 1944, to Jan 11, 1945
that I last saw her alive on Jan 11, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
54 10 2 hr. 1 min.

Immediate cause of death Carcinoma of the stomach
Due to.....
Duration

9. Birthplace Harrison City Iowa
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death)
Major findings: 46 lb
Of operations.....
Of autopsy.....
PHYSICIAN

11. Industry or business
12. Name Wm H. Jones
13. Birthplace Iowa City Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Leona L. Woods
15. Birthplace Harrison City Iowa
(City, town, or county) (State or foreign country)

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)
(a) Means of injury.....

16. (a) Informant Mrs John C. Schreyer
(b) Address Independence, Mo
17. (a) Burial (b) Date thereof 1-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mount Hope Cem.
18. (a) Signature of funeral director Robert R. ...
(b) Address Independence, Mo
19. (a) 1-13-1945 (b) James W. Ross
(Date received local registrar) (Registrar's signature)

23. Signature Dr. Ruth V. Anderson
Address Independence, Mo Date signed 1/13/45

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

8000

1163

FEB 26 1945

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

Roland Speake

Licensed Embalmer No.

3604

P. O. Address

Indep 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.