S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1945

Registration District No. 2

THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 12688

Primary Registration District No. 4004

Registrar's No. 23

**1. PLACE OF DEATH:**

(a) County: Andrew

(b) City or town: Bolckow
(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 years, months or days)
In this community 59 yrs

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: Andrew

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

(d) Street No. ____
(If rural, give location)

(e) Citizen of foreign country? no. (~~Yes~~ or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Terrel Raymond Schildknecht

3. (b) If veteran, name war: —

3. (c) Social Security No. —

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Divorced

6. (b) Name of husband or wife: Helen Stewart

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

7. Birth date of deceased: June (Month) 9 (Day) 1885 (Year)

8. AGE: Years 59 Months 8 Days 24 If less than one day ____ hr. ____ min.

9. Birthplace: Nodaway Co (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Retired Farmer

11. Industry or business ____

MOTHER FATHER

12. Name: Charles Schildknecht

13. Birthplace: Frederick Co (City, town, or county) Maryland (State or foreign country)

14. Maiden name: Catherine Hocket

15. Birthplace: un Known (City, town, or county) Ind. (State or foreign country)

16. (a) Informant: Leslie Schildknecht

(b) Address: Bolckow Mo

17. (a) B (Burial, cremation, or removal) (b) Date thereof 3-6-1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Bolckow

18. (a) Signature of funeral director: E. C. Crist

(b) Address: Savannah Mo

19. (a) 3-6-1945 (Date received local registrar) (b) F H Fritchman (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 3 year 1945 hour 9 minute A M.

21. I hereby certify that I attended the deceased from Oct-1- 1944 to Mch-3- 1945 that I last saw h. alive on Feb-25- 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis — Duration: 5 yrs

Due to: Mitral Regurgitation

Due to: ____

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature: W Logan Wood (M. D. ~~or other~~)

Address: Bolckow, Mo. Date signed 3/9-45

1092 (Licensed Embalmer's Statement on Reverse Side)

## 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.**