

FILED MAY 8 1945

Registration District No. _____

Primary Registration District No. 1000Registrar's No. 484

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
84 Avr Lawn Addition /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 1 Day
 years, months or days)

3. (a) PRINT FULL NAME James Michael Schubert3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife None 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased May 2 1945
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>1</u>	hr. _____ min.

9. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Infant11. Industry or business None

12. Name Dave M. Schubert
 13. Birthplace St. Joseph Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Josephine Bindell
 15. Birthplace Unknown Kansas
 (City, town, or county) (State or foreign country)

16. (a) Informant Dave M. Schubert(b) Address 84 Avr Lawn Addition17. (a) Burial (b) Date thereof May 3, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mt. Olivet Cemetery(a) Signature of funeral director Herbert W. Schubert(b) Address 1802 Union St. St. Joseph, Mo.19. (a) May 3, 1945 (b) Herbert W. Schubert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
 (If outside city or town limits, write "RURAL")
 (d) Street No. 84 Avr Lawn Addition
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3
year 1945 hour 5 minute 00 A.M.21. I hereby certify that I attended the deceased from
May 2 1945 to May 3 1945
that I last saw him alive on May 2 1945
and that death occurred on the date and hour stated above.Immediate cause of death Premature Duration _____

Due to _____

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 sta-
tistically.

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 Angeletta Wenzel (M. D. or other) Midwife
Address 5008 1/2 DuFayette St. Date signed _____

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

1377

(Licensed Embalmer's Statement on Reverse Side)

J. M. W.

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.....

NOT EMBALMED.

Licensed Embalmer No.....

P. O. Address.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12928

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 484

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(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

James M. Schubert
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 S

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

7. Birth date of deceased May 2 (Month) 1945 (Day) 1945 (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (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) Helen J. Piskile (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 _____ Day _____ Year 1945 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ 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) (c) Means of injury _____

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

Address 3003 ... Date signed 5-24-45

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

12928