

FILED OCT 10 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. **30307**

Registration District No. **53**

Primary Registration District No. **3010**

Registrar's No. **286**

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau

(c) Name of hospital or institution: Southeast Mo Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days
In this community 8 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cape Gir 16

(c) City or town Tulout Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FRIEDA SCHOENBORN

3. (b) If veteran, name war ✓

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 13th
year 1945 hour 2 minute 15 P. M.

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife Otto Schoenborn

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

7. Birth date of deceased Sept 4, 1868
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 20, 1945, to Sept 13, 1945
that I last saw her alive on Sept 13, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years 77 Months 0 Days 9
If less than one day hr. _____ min. _____

Immediate cause of death Cerebral hemorrhage Duration 3 day

Due to hypertension 5 yr

Due to _____

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

10. Usual occupation Housekeeper

Other conditions arterial sclerosis 10 yr
(Include pregnancy within 3 months of death)

11. Industry or business _____

MOTHER FATHER { 12. Name Frederick Wilke

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Louisa Daumel

15. Birthplace Germany
(City, town, or county) (State or foreign country)

Major findings: _____

Of operations _____

Of autopsy (2)

Underline the cause to which death should be charged statistically.

16. (a) Informant Glebert J. Wilke

(b) Address Jackson Mo RFD 2

17. (a) Burial (b) Date thereof Sept 16, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grange Cemetery

18. (a) Signature of funeral director J. C. Cracraft

(b) Address Jackson Mo

19. (a) 9-14-45 (b) J. H. Phelps
(Date received local registrar) (Registrar's signature)

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)

(2) Means of injury 0

23. Signature T. E. Ruff M.D. (M. D. or other) _____
Address Jackson Mo Date signed 9/14/45

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

District Health Officer No. 4
District File Number 1045-1152
Date Filed 10-6-45

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 J. G. Graham

Licensed Embalmer No. 4010

P. O. Address Interville, 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.