

No. 2
M-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

33110

FILED NOV 6 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 94

Primary Registration District No. 40-46-117A

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Hartsburg, Mo. ~~Kibberk~~
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Cedar
Cedar Township
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community 50 yrs.
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town Hartsburg, Mo. Rural
(If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME Henry William Schneider

(b) If veteran, name war no

(c) Social Security. No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 7 year 1945 hour 7 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from January 1943 to 10/7/45 that I last saw him alive on 10/6 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

(b) Name of husband or wife Anna Hasenjaeger alive _____ years

7. Birth date of deceased February 15, 1867
(Month) (Day) (Year)

Immediate cause of death: Leukemia Thrombosis
Pneumonia

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

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

Years	Months	Days	hr.	min.
78	7	23		

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

10. Usual occupation Farmer

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER {

11. Industry or business _____

12. Name Unk

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

14. Maiden name Unk

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

16. (a) Informant Fred Schnieder

(b) Address Hartsburg, Mo.

17. (a) Burial (b) Date thereof 10/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Knollen Cemetery

18. (a) Signature of funeral director Victor Buscher

(b) Address Jefferson City, Mo.

19. (a) 10/12/45 (b) Max P. Blasco
(Date received from 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) (e) Means of injury _____

23. Signature W. P. Megee (M. D. or other) _____

Address Hartsburg Date signed 10/12

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

1610

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 11-5-45

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 Victor Buescher

Licensed Embalmer No. 3701

P. O. Address Jefferson City, 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.

Registration District No. 35

Primary Registration District No. 5117A

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

1. PLACE OF DEATH

(a) County Boone

(b) City or town Hartsburg Rural
(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 Henry W. Schneider

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 wid

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Feb. 15 1945
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 13 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) Mrs. Rose Blacock
(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 Oct day _____
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 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)
(e) Means of injury _____

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

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

33110