

Registration District No. **47** Primary Registration District No. **3008**

1. PLACE OF DEATH:

(a) County **Callaway**

(b) City or town **Fullerton**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **State Hospital No 1 2**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 days** (Specify whether years, months or days)

In this community **5 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cole**

(c) City or town **Jefferson City** Rural **1**  
(If outside city or town limits, write "RURAL.")

(d) Street No **R.F. 10 #3**

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **John N. Sochela**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **19** year **1945** hour **6-45** minute **P.** M.

21. I hereby certify that I attended the deceased from **10-14-45** 19 to **10-19-45** 19, that I last saw him alive on **10-19-45** 19, 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 **Married**

6. (b) Name of husband or wife **Minnie Sochela**

6. (c) Age of husband or wife if alive **82** years

7. Birth date of deceased **July 17 1867**  
(Month) (Day) (Year)

Immediate cause of death **Myocarditis**

Due to **Atherosclerosis**

8. AGE: Years **78** Months **3** Days **2** If less than one day hr. min.

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

9. Birthplace **Cole County** **Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name **Lebert Sochela**

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

14. Maiden name **St.**

15. Birthplace **St.** **9**  
(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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

16. (a) Informant **Record**

(b) Address \_\_\_\_\_

17. (a) **Burial** (b) Date thereof **10-23-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green View Cemetery, N.W. of Gordon, Mo.**

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **10-19-45** (b) **Joan M. ...**  
(Date received local registrar) (Registrar's signature)

Signature **R.P. Price** (M. D. or other) **Mo**

Address **Fullton Mo** Date signed **10-19-45**

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

14  
1  
2

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 11-9-45

JUL 26 1949

MAY 10 1954

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. 1786  
working under my personal supervision.

Signed

Licensed Embalmer No. 1786

P. O. Address Gilbert St Mrs

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.