

FILED NOV 14 1945
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 234

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson City, Mo.
(c) Name of hospital or institution: ST MARY'S HOSPITAL
(d) Length of stay: In hospital or institution one day
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cole
(c) City or town Eugene, Mo.
(d) Street No. R.R.
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME — John William Schulte

3. (b) If veteran, name war — 3. (c) Social Security No. —

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased 10 28 45
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
38 hr. 15 min.

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

10. Usual occupation None

11. Industry or business —

12. Name John Schulte

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

14. Maiden name CLARA HEAFY

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

16. (a) Informant John Schulte
(b) Address Eugene Mo

17. (a) Removal & Burial (b) Date thereof Oct 30 - 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mary's Home

18. (a) Signature of funeral director John Schulte
(b) Address Eugene Mo

19. (a) Oct 30 - 1945 (b) R.G. Dorriss MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29
year 1945 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from 10/28/45
10 19. to 70 29 1945

that I last saw h. — alive on — 19—
and that death occurred on the date and hour stated above.

Immediate cause of death —

Due to Pneumonia

Due to Collapsed lung, R
(7 1/2 Mo)

Other conditions —
(Include pregnancy within 3 months of death)

Major findings: 159
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 M. R. Reddick (M. D. or other) —

Address — Date signed 10/30/45

Duration

1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 11-19-45

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.

Not Embalmed

Signed.....

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.