

**FILED** DEC 6 1945

Registration District No. 289

Primary Registration District No. 4423

Registrar's No. 16

1. PLACE OF DEATH:  
 (a) County Platte  
 (b) City or town Weston  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: none  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution none (Specify whether years, months or days)  
 In this community entire life

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Platte  
 (c) City or town Weston (If outside city or town limits, write "RURAL")  
 (d) Street No. none (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Annie Hunt Schindler  
 3. (b) If veteran, name war XX  
 3. (c) Social Security No. XX

4. Sex female 5. Color or race white  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife Walter Schindler  
 6. (c) Age of husband or wife if alive XX years  
 7. Birth date of deceased May 11 1872  
 (Month) (Day) (Year)

8. AGE: 73 Years 4 Months 21 Days  
 If less than one day hr. min.

9. Birthplace Weston Missouri  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
 12. Name William Hunt  
 13. Birthplace XX Kansas  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Diza Pierce  
 15. Birthplace Gower Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Raymond Pepper  
 (b) Address Weston, Missouri

17. (a) Burial (b) Date thereof Oct. 5, 1945  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Laurel Hill Cem.

18. (a) Signature of funeral director Wagon Funeral Home  
 (b) Address Weston, Missouri  
 19. (a) 11-15-45 (b) Mrs. Alpha Rollins  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month October day 1st  
 year 1945 hour 8 minute 30 P.M.  
 21. I hereby certify that I attended the deceased from January, 14,  
1944 to October 1, 1945  
 that I last saw her alive on October 1, 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Adenocarcinoma of head of pancreas, involving gall-bladder and duodenum.  
 Due to Marked jaundice present.  
 Due to XXXXXX

Duration  
2 yrs?

Other conditions Partial intestinal obstruction  
 (Include pregnancy within 3 months of death)

Major findings: No operation  
 Of operations \_\_\_\_\_  
 Of autopsy Adenocarcinoma, as given above.

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) XXXXX  
 (b) Date of occurrence XXXX  
 (c) Where did injury occur? XXXXX  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? XXXXX  
 While at work? XXX (Specify type of place) (e) Means of injury XXX  
 23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address Weston Missouri Date signed 11/15/45

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

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-17-39  
X37823

**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 *W. R. Jaugh*

Licensed Embalmer No. *4023*

P. O. Address *Weston, 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. 280

Primary Registration District No. 4423

**1. PLACE OF DEATH:**

(a) County Platte

(b) City or town Wenton  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

**3. (a) PRINT FULL NAME** Annie H. Schindler

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

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

4. Sex F

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 \_\_\_\_\_

7. Birth date of deceased May 11 1905  
(Month) (Day) (Year)

**8. AGE:** Years 73 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) Ms. Debra Rollins (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 Dec Day 10 Year 1948 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)

**PHYSICIAN**

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 Lewis E. Calvert (M. D. or other) \_\_\_\_\_  
Wenton, Mo. Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

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

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