

**FILED** 316  
AUG 12 1946

Primary Registration District No. 10244

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County WASHINGTON  
 (b) City or town CADET MO - RURAL -  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 15 YRS.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MISSOURI (b) County WASHINGTON  
 (c) City or town CADET  
(If outside city or town limits, write "RURAL")  
RURAL. 3 MI N/W.  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? YES. 1) (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME EDITH ISABELLE SCHMIDT  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month MAY day 27  
 year 1946 hour 12 minute 10 P.M.  
 21. I hereby certify that I attended the deceased from Nov.  
2, 1946, to May 27, 1946  
 that I last saw her alive on May 20, 1946  
 and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color of race WHITE  
 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife CECIL S. SCHMIDT  
 6. (c) Age of husband or wife if alive 49 years  
 7. Birth date of deceased NOV 25 1898  
(Month) (Day) (Year)

Immediate cause of death Carcinoma of uterus.  
 Duration 6 mo?

8. AGE: Years 47 Months 6 Days 2  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

9. Birthplace ST. CHARLES MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business \_\_\_\_\_  
 12. Name WILLIAM GINGER  
 13. Birthplace MO. U  
(City, town, or county) (State or foreign country)  
 14. Maiden name EMMA CONEY  
 15. Birthplace MO. U  
(City, town, or county) (State or foreign country)

Major findings: Of operations not operated  
 Of autopsy 48h  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant CECIL SCHMIDT  
 (b) Address CADET MO RI.

17. (a) BURIAL (b) Date thereof 5 29 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation OLD MINES MO.

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

18. (a) Signature of funeral director BOYER FUNERAL HOME  
 (b) Address POTOSI MO.  
 19. (a) June 10 46 (b) Mrs. G. F. Leonard  
(Date received local registrar) (Registrar's signature)

23. Signature Joseph L. Thurman (M. D. or other) \_\_\_\_\_  
 Address Potosi, Mo. Date signed 5-28-46

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

1000

RECEIVED

District Health Officer No. 4  
Net File Number 846-2489  
Date Filed 8-10-46

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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 \_\_\_\_\_  
*R. H. Boyer*

Licensed Embalmer No. 14158

P. O. Address To To 51 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.