

State File No.

FILED APR 28 1947

Registration District No.

Primary Registration District No. 3048

Registrar's No. 80

1. PLACE OF DEATH:

(a) County Madaway
 (b) City or town Marquette
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution St. Francis
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 days
(Specify whether)
 In this community all his life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madaway
 (c) City or town Clyde
(If outside city or town limits, write "RURAL")
 (d) Street No. 0
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME JOHN N. SCHIEBER
 (b) If veteran, name war

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 17
 year 1947 hour 11 minute 10 P. M.

21. I hereby certify that I attended the deceased from April 8, 1947, to April 17, 1947,
 that I last saw him alive on April 17, 1947,
 and that death occurred on the date and hour stated above.

3. (c) Social Security No.

4. Sex male Color or race white
 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Frances Schieber
 6. (c) Age of husband or wife if alive 69 years
 7. Birth date of deceased Jan 27 1871
(Month) (Day) (Year)

Immediate cause of death Route pulmonary edema **Duration** 24 hrs.

Due to Cardiac failure **4+ days**

Due to Auricular fibrillation **4+ days**

Other conditions 95
(Include pregnancy within 3 months of death)

Major findings:
 Of operations

Of autopsy

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

8. AGE: Years 76 Months 2 Days 19
If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name John Schieber
 13. Birthplace St. Mary's
(City, town, or county) (State or foreign country)

14. Maiden name Kennetha Meyer
 15. Birthplace St. Mary's
(City, town, or county) (State or foreign country)

16. (a) Informant Laurel Schieber
 (b) Address Conception St. Ma

17. (a) Burial (b) Date thereof 4-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Columba

18. (a) Signature of funeral director St. Adams & Phillips
 (b) Address Conception St. Ma

19. (a) April 19 1947 (b) Bess Holt
(Date received local 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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place) 0
 While at work? (e) Means of injury

23. Signature Paul J. Kadull (M. D. or other) M.D.
 Address Conception Junct., Mo. Date signed 4/18/47

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

74
 1
 2

JUL 11 1950

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.....

Leroy H. Phillips

Licensed Embalmer No. *1898*

P. O. Address.....

Staring, 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.