

No. 2
-12-45
-5-17-39
I X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 30 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21491**
Registrar's No. **42**

Registration District No. **174** Primary Registration District No. **3035**

1. PLACE OF DEATH:
(a) County **Lafayette**
(b) City or town **Livingston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **23rd St 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **Life** years, months or days

3. (a) PRINT FULL NAME **JOSEPH SCHENCK**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **MAO** 5. Color or race **W**
6. (a) Single, widowed, married, divorced, **married**
6. (b) Name of husband or wife **not known** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Feb 5 1899**
(Month) (Day) (Year)

8. AGE: Years **58** Months **2** Days **27** If less than one day _____ hr. _____ min.

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

10. Usual occupation **laborer**

11. Industry or business _____

MOTHER FATHER

12. Name **Carl Schenck** 4
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Margaret Sparker**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Herbert Schenck** E
(b) Address **Livingston, Mo**

17. (a) **Burial** (b) Date thereof **5-4-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Livingston, Mo**

18. (a) Signature of funeral director **Herbert Schenck**
(b) Address **Livingston**

19. (a) **14 June 47** (b) **Herbert Schenck**
(Date received local registrar) (Registrar's signature) **151**

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO** (b) County **Lafayette** 54
(c) City or town **Livingston** 3
(If outside city or town limits, write "RURAL") 2
(d) Street **23rd St** 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **2**
year **1947** hour **1** minute **A** M.
21. I hereby certify that I attended the deceased from **2 May 47**
_____, 19____, to **2 May**, 19**47**
that I last saw him alive on **2 May 47**, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**
Duration _____

Due to _____
Due to _____

Other conditions _____
(include pregnancy within 3 months of death)

Major findings:
Of operations **94A**
Of autopsy _____
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) _____
(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) (e) Means of injury _____
Signature **J. W. Ward MD** (M. D. or other) _____
Address **Livingston, Mo** Date signed **5/3/47**

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 6-28-47

Ward

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 *J. W. McLean*

Licensed Embalmer No. 2983

P. O. Address *Leesburg, Va*

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.