

Registration District No. **194**

Primary Registration District No. **5717**

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

**1. PLACE OF DEATH:**  
 (a) County **Mc Donald**  
 (b) City or town **Jackit Mo**  
(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 years, months or days)  
 In this community **Lifetime**

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Missouri** (b) County **Mc Donald**  
 (c) City or town **Jackit**  
(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 \_\_\_\_\_

**3. (a) PRINT FULL NAME** **Marshall Schell**  
 3. (b) If veteran, name war  3. (c) Social Security No.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **June** day **7**  
 year **1947** hour **10** minute **15 P** M.  
**21. I hereby certify that I attended the deceased from** **6-5-47**  
 \_\_\_\_\_, 19\_\_\_\_, to **6-7-47**, 19\_\_\_\_;  
 that I last saw h. \_\_\_\_\_ alive on **6-5-47**, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

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

Immediate cause of death  
**Hypertension**  
**for Cerebral**  
**Haemorrhage**  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

**8. AGE:** Years **52** Months **10** Days **1**  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

**9. Birthplace** **Mc Donald Co Mo**  
(City, town, or county) (State or foreign country)

**10. Usual occupation** **Farmer**

**11. Industry or business** **Farmer**  
**12. Name** **Jesse Schell**  
**13. Birthplace** **Mc Donald Co Mo**  
(City, town, or county) (State or foreign country)  
**14. Maiden name** **Nancy Gendengraft**  
**15. Birthplace** **Mc Donald Co Mo**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **Virgil Schell**  
**(b) Address** **Esperfield Ark R 2**

**17. (a) Burial** **Burial** **(b) Date thereof** **6-10-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** **Roller Cemetery**

**18. (a) Signature of funeral director** **Ralph Miller**  
**(b) Address** **Pea Ridge Ark**

**19. (a) 6-22-47** **(b) O. E. Plumlee**  
(Date received local registrar) (Registrar's signature)

**Other conditions** \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
**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?** \_\_\_\_\_

**23. Signature** **Geo H. Row** **(M. D. or other)**  
(Specify type of place) (a) Means of injury  
**Address** **Rogers Ark** **Date signed** **6-17-47**

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

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

no fee

X

1946  
7-4-2

*Dr. John Rogers*

**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.....

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.

Registration District No. 194

Primary Registration District No. 5717

1. PLACE OF DEATH:

(a) County McDonald  
(b) City or town Jochet  
(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 Marshall Schell

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased: Aug 6 (Month) 18 (Day) 1906 (Year)

8. AGE: Years 52 Months 10 Days 10 (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) June 27 47 (b) D. E. Plumb  
(Date received local registrar) (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 \_\_\_\_\_ year 1947 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 \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

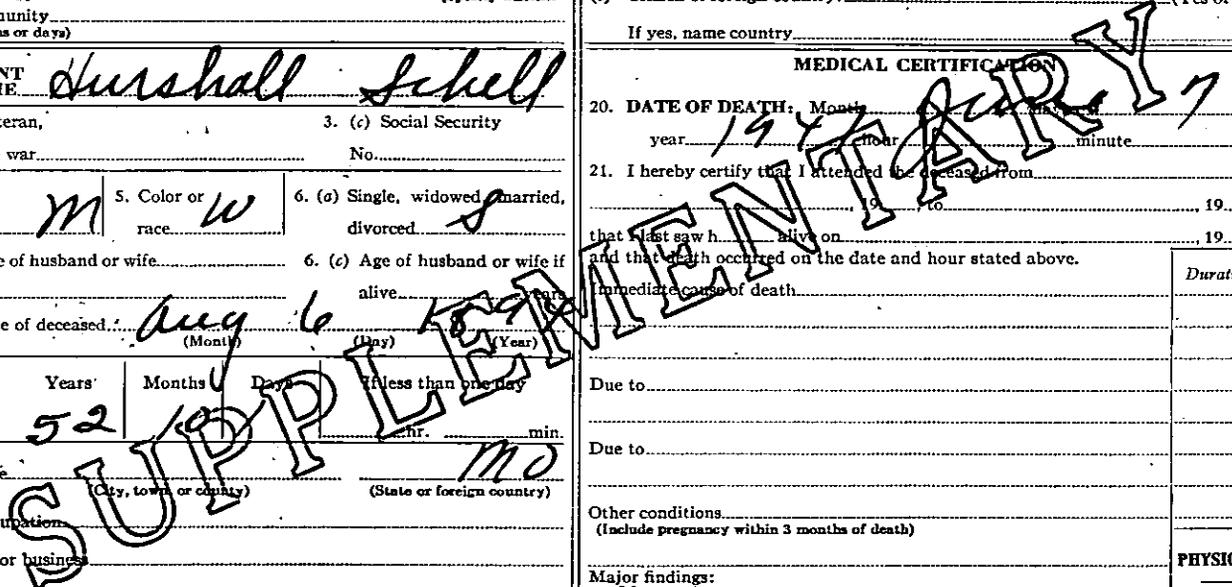
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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



S-21573