

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21892**
Registrar's No. **53**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 7 1947

Registration District No. **280**

Primary Registration District No. **442-3**

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

1. PLACE OF DEATH:

(a) County Platte
(b) City or town Weston, 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 _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Platte
(c) City or town Weston Mo.
(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 ANNA SCHMIDT

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

4. Sex Female 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 _____

7. Birth date of deceased 8 29 1954
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
92 10 13 hr. min. 0

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

10. Usual occupation House Keeper

11. Industry or business _____

12. Name Antone Schmidt 4

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Hartman

15. Birthplace France
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) Burial (b) Date thereof June 14, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sarel Hill

18. (a) Signature of funeral director Vaughn Funeral Home

(b) Address Weston Mo.

19. (a) 6-18-47 (b) Mrs. Ophelia Rollins
(Date received local registrar) (Registrar's signature) 259

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12
year 1947 hour 10 minute _____ A. M.

21. I hereby certify that I attended the deceased from June 5, 1947, to June 12, 1947
that I last saw her alive on June 12, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to arteriosclerosis

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

Major findings: Of operations 43A
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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury 2

23. Signature [Signature] (M. D. or other) D.O.
Address Weston Date signed 6/12/47

**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... *W. R. Vaughn*
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.