

FILED DEC 11 1947

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 423

**1. PLACE OF DEATH:**

(a) County Callaway

(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp. # 1 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since 6-6-1947  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Lincoln 14

(c) City or town Moscow Mills 2  
(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 0-

**3. (a) PRINT FULL NAME** Henry Schmidt

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married divorced marriage

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

7. Birth date of deceased: Dec 11 1868  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 4  
year 1947 hour 7 minute 5:0 P. M.

21. I hereby certify that I attended the deceased from 6-6-1947 to 12-4-1947  
that I last saw him alive on 12-4-1947  
and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<u>79</u>		<u>7</u>	hr. _____ min. _____

Immediate cause of death Bronchopneumonia 4 days

Due to Generalized arteriosclerosis

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

10. Usual occupation farmer

Due to Cardiac enlargement, arteriosclerosis and elongation of the heart

Other conditions Duodenal Peptic Ulcers

(Include pregnancy within 3 months of death)

with much muscle deterioration

**MOTHER FATHER**

11. Industry or business \_\_\_\_\_

12. Name Joseph Schmidt

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

14. Maiden name Mary Gude

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

Major findings: \_\_\_\_\_

Of operations none

Of autopsy 2 107

16. (a) Informant Hosp. records

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

17. (a) Removal (b) Date thereof 12-4-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Tray type

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

(b) Address Fulton Mo.

19. (a) 12-4-1947 (b) Jovic Moscovich  
(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? \_\_\_\_\_  
(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 0-

23. Signature J.C. Caldwell publ. satn (M. D. or other)

Address State Hosp. # 1 Date signed 2/4/47

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

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed 12-10-47

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.....

*Walter J. Haines, Jr.*, Registered Apprentice No. *82*  
working under my personal supervision.

Signed *Denzil C. Browning*

Licensed Embalmer No. *2724*

P. O. Address. *Fulton 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.