

No. 2
M-5-43
5-17-39
K38671

FILED DEC 3 1947

State File No. _____

Registration District No. 52

Primary Registration District No. 3009

Registrar's No. 82

1. PLACE OF DEATH:

(a) County Cape Girardeau

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

(c) Name of hospital or institution:
219 N. 1st East St.
(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 Missouri (b) County Cape Girardeau

(c) City or town Jackson Mo. 16
(If outside city or town limits, write "RURAL")

(d) Street No. 219 N. 1st East St. 2
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country _____ 0

3. (a) PRINT FULL NAME Rudolph Ernst Schoen

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

4. Sex M **5. Color or race** W

6. (a) Single, widowed, married, 2 divorced widowed

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
alive _____ years

7. Birth date of deceased. Sept 7 1873
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>1</u>	<u>16</u>	hr. _____ min. _____

9. Birthplace. Peachontas Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation. Doctor of Medicine

11. Industry or business _____

12. Name. Gustav G. Schoen

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

14. Maiden name. Anna Selner

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

16. (a) Informant. Mrs. J. E. Schoen

(b) Address. 103 S. Blvd. Cape Girardeau Mo.

17. (a) Burial _____ **(b) Date thereof.** 11/25/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Memorial Park

18. (a) Signature of funeral director. Mrs. Cora Fairmoulde

(b) Address. Jackson Mo.

19. (a) 11-25-47 **(b) D. E. Luff**
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23 rd
year 1947 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from Dec
_____, 1942 to Nov 23, 1947
that I last saw h. 12 alive on Nov 23, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral hemorrhage 2 day

Due to _____ arterio sclerosis 10 yrs

Due to _____

Other conditions: Pericardial Anemia 4 yrs
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy cholecystitis 3 yrs
with Lithaexis

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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature D. E. Luff (M. D. or other) MD

Address Jackson Mo. **Date signed** 11-23-47

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

MOTHER FATHER

JAN 15 1948

RECEIVED

Health Officer No. 4
Wife Number 1242-1517
No. 12-2-47

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Ba Meyer

Licensed Embalmer No. 3051

P. O. Address Jackson 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.