

No. 2
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38987

FILED NOV 19 1947

Registration District No. 219 Primary Registration District No. 5791 Registrar's No.

1. PLACE OF DEATH:

(a) County Moniteau

(b) City or town Rural - Near Russellville
(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

3. (a) PRINT FULL NAME Mrs Mary Wyss

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 Widowed

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

7. Birth date of deceased: July 2 1846
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>101</u>	<u>4</u>	<u>1</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Henty J. Schulze

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

14. Maiden name Fendericke Schulze

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

16. (a) Informant George Wyss

(b) Address Russellville, Missouri

17. (a) Burial (b) Date thereof 11-5-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jamestown, Mo

18. (a) Signature of funeral director _____

(b) Address Russellville, Mo

19. (a) 11-25-47 (b) C. A. Nail
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Moniteau

(c) City or town Rural Near Russellville 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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 3
year 1947 hour 7 minute 30P M.

21. I hereby certify that I attended the deceased from Jan 1941 to Nov 3 1947
that I last saw her alive on Nov 3, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Central Thrombosis Duration 1 week

Due to Traumatic Thrombosis

Due to Fall from bed

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

Major findings: cf 10
Of operations 17

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) Accident 216

(b) Date of occurrence Oct 27 or 1547

(c) Where did injury occur? Demerill Cole mo
(City or town) (County) (State)

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

(Specify type of place) _____
While at work? _____ (e) Means of injury Head injury for feet D.O. 2

23. Signature E. M. Ehrhart (M. D. or other)

Address Russellville Date signed 11/3/47

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number
NOV 18 1947
Date Filed

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. 2870
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. 219

Primary Registration District No. 5791

1. PLACE OF DEATH:

(a) County Monticerni
(b) City or town Rural near Russellville
(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

3. (a) PRINT FULL NAME

May Wysz

3. (b) If veteran, name war _____

3. Social Security No. _____

4. Sex F

5. Color or race w

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____

7. Birth date of deceased _____

July 2
(Month) (Day) (Year)

8. AGE: Years _____

101

Months _____

Days _____

(If less than one day)

hr. _____ min. _____

9. Birthplace _____

(City, town or county)

(State or foreign country) Ohio

10. Usual occupation _____

11. Industry or business _____

12. Name _____

Henry J. Schulz

13. Birthplace _____

(City, town or county)

(State or foreign country) Germany

14. Maiden name _____

Frederick Schulz

15. Birthplace _____

(City, town, or county)

(State or foreign country) Germany

16. (a) Informant _____

George Wysz

(b) Address _____

Russellville, Mo

17. (a) _____

(Burial, cremation or removal)

(b) Date thereof _____

(Month) (Day) (Year) 11-5-47

(c) Place: burial or cremation _____

Jamestown

13. (a) Signature of funeral director _____

(b) Address _____

Russellville, Mo

19. (a) _____

(Date received local registrar)

(b) _____

(Registrar's signature)

Bill Hall

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Monticerni
(c) City or town Rural near Russellville
(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 Nov
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 cerebral thrombosis

Due to _____

Due to fell from bed

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

Major findings: _____

Of operations _____

Of autopsy _____

Duration

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) accident

(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) _____ (Means of injury)

23. Signature E. M. Eberhart M. D. or other DO

Address Russellville Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

38987