

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44043

State File No. _____

FILED DEC 17 1947

Registration District No. 338

Primary Registration District No. 6214

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural Clear Creek Twp.
(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 about 60 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon

(c) City or town Rural
(If outside city or town limits, write "RURAL.")

(d) Street No. Clear Creek Twp.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Margaret Tschanz

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 29
year 1947 hour 7 minute P M.

21. I hereby certify that I attended the deceased from NOV 22, 1947, to NOV 29, 1947,
that I last saw her alive on NOV 29, 1947,
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Fredrick Tschanz

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

7. Birth date of deceased February 17 1855
(Month) (Day) (Year)

Immediate cause of death Metral insufficiency

Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>92</u>	<u>9</u>	<u>12</u>	_____ hr. _____ min.

Due to _____

Due to _____

9. Birthplace Switzerland (City, town, or county) (State or foreign country) 5

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

10. Usual occupation housewife

Major findings: Of operations _____

Of autopsy _____

11. Industry or business _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

12. Name do not know

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

14. Maiden name do not know

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

16. (a) Informant Mrs. Lydia Tschanz

(b) Address Harwood Mo.

17. (a) Burial (b) Date thereof 12/1/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leller Cemetery

18. (a) Signature of funeral director Lewis J. Sofu

(b) Address Schell City, Mo.

22. If death was due to external causes, fill in the following:

(c) 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 W. Dawson (M. D. or other) _____

Address El Dorado Sts. Date signed 11/30/47

19. (a) Dec 1-1947 (b) M. Sabah Elway
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED
DISTRICT HEALTH OFFICE No. 7
11-47-1456
District File Number
19-17-47
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..... *Marion M. Lewis*
Licensed Embalmer No. *3084*
P. O. Address..... *Schell City, 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.