

FILED FEB 10 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5847  
Registrar's No. 5847

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 113 PRIMARY REG. DIST. NO. 5431

1. PLACE OF DEATH  
a. COUNTY Transylvania

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE MO. b. COUNTY Transylvania

b. CITY (If outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (In this place)  
Rural Prairie 3 1/2

c. CITY (If outside corporate limits, write RURAL and give township)  
Rural Prairie

d. FULL NAME OF (If not in hospital or institution, give street address or location)  
60

d. STREET ADDRESS (If rural, give location)  
2nd Dist.

3. NAME OF DECEASED  
a. (First) Effie b. (Middle) Theresa c. (Last) Schumacher

4. DATE OF DEATH (Month) (Day) (Year)  
10-17-49

5. SEX Female 6. COLOR OR RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 9-14-1870 9. AGE (In years last birthday) 78 Months 4 Days 3 IF UNDER 15 Hrs. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wife 10b. KIND OF BUSINESS OR INDUSTRY Home work 11. BIRTHPLACE (State or foreign country) Galena Ill 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Brook Hanna 13b. MOTHER'S MAIDEN NAME Mary E Zangher 14. NAME OF HUSBAND OR WIFE Danish O. Schumacher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 6 17. INFORMANT'S SIGNATURE OR NAME Wm. K. Ruge ADDRESS 7314 Woodlawn

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)  
\*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Coronary Thrombosis.

ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) General Arteriosclerosis  
DUE TO (c) None

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 40 19b. MAJOR FINDINGS OF OPERATION 4201 20. AUTOPSY? YES  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? 0

22. I hereby certify that I attended the deceased from Dec 10, 1948, 1948, to 10-17, 1949, 1949, that I last saw the deceased alive on Dec 10, 1948, and that death occurred at 3:00 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. E. Mitchell, Jr. 23b. ADDRESS 317 Clair 23c. DATE SIGNED 10-17-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 1-19-49 24c. NAME OF CEMETERY OR CREMATORY Oak Hill & Cemetery 24d. LOCATION (City, town, or county) (State) Transylvania Co

DATE REC'D BY LOCAL REG. 1-18-1949 REGISTRAR'S SIGNATURE E. J. Worthington 25. FUNERAL DIRECTOR'S SIGNATURE Sherrill Mitchell ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed FEB 9 1949

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Sheldon Kitchell

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3873

P. O. Address St. Clair, 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.