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FILED FEB 3 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3891

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>371</u>		PRIMARY REG. DIST. NO. <u>6260</u>		Registrar's No. <u>5</u>			
1. PLACE OF DEATH a. COUNTY <u>Webster</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Webster</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Diggins</u>		c. LENGTH OF STAY (In this place) <u>48 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Diggins Mo.</u>		d. STREET ADDRESS (If rural, give location) <u>9</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS _____					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fred</u> b. (Middle) <u>Christopher</u> c. (Last) <u>Schroeder</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 20 1949</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>June 20, 1860</u>			
9. AGE (In years last birthday) <u>88</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Germany</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) _____		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13a. FATHER'S NAME <u>John Schroeder</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Barbara Deierling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Rudy Schroeder</u>		ADDRESS <u>Diggins Mo.</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>				DUE TO (b) <u>Myocardial Degeneration</u>				<u>2 yrs</u>	
ANTECEDENT CAUSES				DUE TO (c) <u>Fractured Right Hip</u>				<u>14 1/2 months</u>	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				II. OTHER SIGNIFICANT CONDITIONS				<u>14 1/2 months</u>	
Conditions contributing to the death but not related to the disease or condition causing death.				CONDITIONAL SUPPLEMENTARY INFORMATION <u>6 00 30</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.) <u>home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Seymour Webster Mo</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>1 26 46 3pm</u>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell on ice</u>					
22. I hereby certify that I attended the deceased from <u>Jan-16, 1945</u> , to <u>Jan 20, 1949</u> , that I last saw the deceased alive on <u>Jan 17, 1949</u> , and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE <u>J. R. Gee</u> (Degree or title) <u>D. O.</u>				23b. ADDRESS <u>Seymour Mo</u>		23c. DATE SIGNED <u>1/20/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 23 1949</u>		24c. NAME OF CEMETERY, OR CREMATORY <u>Fordland Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Fordland Mo.</u>			
DATE REC'D BY LOCAL REG. <u>1-26-49</u>		REGISTRAR'S SIGNATURE <u>Lester W. Good</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Kelley Terrell Beraman</u>		ADDRESS <u>Seymour Mo</u>			

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

RECEIVED  
Division of Health Officer No. 6  
District File No. 149-115  
Date Filed 1-31-49

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. 282

working under my personal supervision.

Signed Max L. Miller  
Student Embalmer

Signed H. H. Kelley

Licensed Embalmer No. 3334

P. O. Address Fordland ms.

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.