

FILED DEC 8 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **36490**BIRTH NO. _____ REG. DIST. NO. **114** PRIMARY REG. DIST. NO. **5433** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Union Rural Route		c. LENGTH OF STAY (in this place) 87		c. CITY OR TOWN Union	
d. FULL NAME OF HOSPITAL OR INSTITUTION		f. STREET ADDRESS (If rural, give location) Rural Route #2		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Aloys	b. (Middle)	c. (Last) Schroeder	(Month) Dec. 5,	(Day)	(Year) 1955

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec 8, 1868	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months 119 Days 9	IF UNDER 24 HRS. Hours 9 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and State or Foreign Country) Union, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Anton Schroeder	13b. MOTHER'S MAIDEN NAME Elizabeth Weiesmann	14. NAME OF HUSBAND OR WIFE Anna Schroder
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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. None	17. INFORMANT'S SIGNATURE OR NAME William Schroeder	ADDRESS Union, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility		DUPLICATE		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute Is of leg		DUPLICATE		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from **2-10**, **1955**, to **Dec 5**, **1955**, that I last saw the deceased alive on **12-2**, **1955**, and that death occurred at **8:15a** m., from the causes and on the date stated above.

23a. SIGNATURE H.M. Lenny (Degree or title)	23b. ADDRESS Union Mo.	23c. DATE SIGNED 10-5-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec 7, 1955	24c. NAME OF CEMETERY OR CREMATORY St. Joseph's Church	24d. LOCATION (City, town, or county) (State) Union Rural Route, Mo
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DATE REC'D BY LOCAL REG. Dec 6-55	REGISTRAR'S SIGNATURE H. I. Cooper 98-0	25. FUNERAL DIRECTOR'S SIGNATURE UNION Funeral Home,	ADDRESS Union, Mo
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(Licensed Embalmer's Statement on Reverse Side)

WHILE PRINTING - USING UNFADING BLACK INK - MAKE A PERMANENT RECORD

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..

Student.....
Signature of Student Embalmer

Signed..... *Harlan Johannabe*

Licensed Embalmer No. *4*

P. O. Address *Union*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license). If embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.