DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 9 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

2321

State File No. _____

Registration District No. 82-6-131 Primary Registration District No. 5456-5469 Registrar's No. 12

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

1. PLACE OF DEATH:
(a) County: Grundy
(b) City or town: Spickard (Rural) (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: / Franklin Inst. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: No (Specify whether years, months or days) In this community: _____

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Grundy
(c) City or town: Spickard (Rural) (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country _____

3. (a) PRINT FULL NAME: JOHN HENRY SCHIERBAUM
3. (b) If veteran, name war: /
3. (c) Social Security No.: /
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Mrs J H Schierbaum (dead)
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: June (Month) 29 (Day) 1857 (Year)

8. AGE: Years 85 Months 6 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace: New York (City, town, or county) (State or foreign country)
10. Usual occupation: Retired Farmer
11. Industry or business: _____
12. Name of father: Henry Schierbaum
13. Birthplace of father: Germany (City, town, or county) (State or foreign country)
14. Maiden name of mother: /
15. Birthplace of mother: / (City, town, or county) / (State or foreign country)
16. (a) Informant: Mrs Will Koon
(b) Address: Spickard R. F. D.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-13-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Berry Cemetery
18. (a) Signature of funeral director: D R Payne & Son
(b) Address: Galt Mo
19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10 year 1943 hour 4 minute 50 P.M.
21. I hereby certify that I attended the deceased from 12-31 1942 to 1-10 1943; that I last saw living alive on 1-10 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral hemorrhage	10 da.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations _____ 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)
(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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: C. J. McClanahan (M. D. or other) per E.C.
Address: Spickard Mo. Date signed 1-11-43

1199

(Licensed Embalmer's Statement on Reverse Side)

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 D K Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galx

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2321

Registration District No. 3

Primary Registration District No. 5469

Registrar's No. 12

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

1. PLACE OF DEATH:
(a) County: Grundy
(b) City or town: Rural
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (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

3. (a) PRINT FULL NAME: John Henry Scherbaum
3. (b) If veteran, name war: C
3. (c) Social Security No.
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years
7. Birth date of deceased: June (Month) 29 (Day) 1858 (Year)
8. AGE: Years 85 Months 6 Days If less than one day hr. min.
9. Birthplace (City, town, or county) N.Y. (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Jan. 15-43 (Date received local registrar) (b) John E. Lill (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year 1943 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY