V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33617
State File No.

FILED NOV 14 1945
Registration District No. Primary Registration District No. 53 13 Registrar's No. 3

1. PLACE OF DEATH:

(a) County COOPER
(b) City or town RURAL North MONITEAU 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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COOPER 27
(c) City or town RURAL (If outside city or town limits, write "RURAL") 0
(d) Street No. (If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country SWITZERLAND

3. (a) PRINT FULL NAME ELIZEBETH SCHNUR
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 12 (Month) 19 (Day) 1888 (Year)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct day 23
year 1945 hour 2 minute 20 P.M.
21. I hereby certify that I attended the deceased from MARCH 10 1944 to Oct 23 1945
that I last saw h[illegible] alive on Oct 22 1945
and that death occurred on the date and hour stated above.

8. AGE: Years	Months	Days	If less than one day
56	10	4	hr. min.

	Duration
Immediate cause of death CEREBRAL HEMORRHAGE 2-28-45	16 hrs
Due to CEREBRAL HEMORRHAGE 2-10-28-45	19 27 45
Due to	
Other conditions (Include pregnancy within 3 months of death)	

9. Birthplace SWITZERLAND 5 (City, town, or county) (State or foreign country)
10. Usual occupation HOUSE WIFE
11. Industry or business

MOTHER FATHER
12. Name JOHN KOBEL
13. Birthplace SWITZERLAND 5 (City, town, or county) (State or foreign country)
14. Maiden name SOPHIA CAUCG
15. Birthplace SWITZERLAND 5 (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address W E Schnur

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-26-45 (Month) (Day) (Year)
(c) Place: burial or cremation MONITEAU EVAN. CEM.

18. (a) Signature of funeral director C. Albert Hornbeck
(b) Address Prairie Home Mo.

19. (a) 10-26-45 (Date received local registrar) (b) A L Meredith (Registrar's signature)

Major findings:
Of operations
Of autopsy $30

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 A L Meredith (M. D. or other) MD
Address Prairie Home Date signed 10-28-45

1416 (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 C. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prairie Home 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.