

Registration District No. 221

Primary Registration District No. 5793

Registrar's No. 14

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

1. PLACE OF DEATH:

(a) County MONITEAU

(b) City or town LINN Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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 MONITEAU

(c) City or town RURAL LINN
(If outside city or town limits, write "RURAL")

(d) Street No. Rural (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: _____

3. (a) PRINTED FULL NAME JOSEPH P. SCHEIPT

3. (b) If veteran, name war: _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 22
year 1947 hour 3 minute 0 M.

4. Sex MALE 5. Color or 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 (Day) (Year)

7. Birth date of deceased: 11 - 9 - 1880
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11 - 16 1947 to 11 - 22 1947
that I last saw him alive on 11 - 19 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Pulmonary Emphysema & Heart Duration 3

8. AGE: Years 67 Months _____ Days 12 If less than one day _____ hr. _____ min.

Due to: _____

Due to: _____

9. Birthplace: MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation: FARMING

Other conditions: _____ (Include pregnancy within 3 months of death)

11. Industry or business: _____

12. Name CHARLES SCHEIPT 4

13. Birthplace MO GERMANY
(City, town, or county) (State or foreign country)

14. Maiden name ELIZABETH FELDER 4

15. Birthplace MO GERMANY
(City, town, or county) (State or foreign country)

Major findings: _____

Of operations: _____

Of autopsy: _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Urban W. J. Linnell

(b) Address St. Louis Mo.

17. (a) BURIAL (b) Date thereof: 11-26-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GEDYON C.E.M.

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? 0

18. (a) Signature of funeral director C. ALBERT HOYNECK

(b) Address Prarie Home Mo

19. (a) Nov 29 - 47 (b) Jada M. Suw...
(Date received local registrar) (Registrar's signature)

23. Signature W. L. Murchick (M. D. or other) _____

Address Prarie Home Date signed 11/22/47

Date Filed DEC 5 1947

District File Number

District Health Officer No. 9

RECEIVED

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 HOYNBECK

Licensed Embalmer No 2714

P. O. Address Grave 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: