

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 11 1943

Registration District No. 94

Primary Registration District No. 4084

Registrar's No. 43

1. PLACE OF DEATH:

(a) County Caldwell  
(b) City or town Cowgill mo  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Caldwell  
(c) City or town Cowgill  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years

3. (a) PRINT FULL NAME John L. Schuster  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3rd  
year 1942 hour 5 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Nov-15 1942, to Dec-3rd 1942  
that I last saw him alive on Dec-2 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis with mitral stenosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Duration

Other conditions (Include pregnancy within 3 months of death)  
O.C. Kilbourn  
Major findings: 920  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature O.C. Kilbourn (M. D. number) \_\_\_\_\_  
Address Cowgill, MO Date signed 12/9/42

8. AGE: Years 74 Months 9 Days 18  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Caldwell Co. - MO  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Leonard Schuster

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

14. Maiden name Minnie Cain

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

16. (a) Informant's own signature Mrs. Ruthie Stegley

(b) Address Cowgill mo

17. (a) Rural (Burial, cremation, or removal) (b) Date thereof Dec 6 1942  
(Month) (Day) (Year)

(c) Place: burial or cremation Cowgill mo

18. (a) Signature of funeral director C. H. Adams

(b) Address Cowgill mo

19. (a) Dec 5 - 1942 (Date received local registrar) (b) E. A. Thompson (Registrar's signature)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39  
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**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.....

Licensed Embalmer No. 2194

P. O. Address Croydon, Mass.

**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, above space should be left blank.**