

FILED JAN 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42597

BIRTH NO. _____		REG. DIST. NO. 274		PRIMARY REG. DIST. NO. 3052		Registrar's No. 393			
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>12 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		06			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Woodland Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>817 W. 3rd</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Augusta</u> b. (Middle) <u>Scheerer</u> c. (Last) <u>Kester</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 31, 1948</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Jan 30, 1889</u>			
9. AGE (In years last birthday) <u>59</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>1</u>		IF UNDER 12 HRS. Hours <u>1</u> Min. <u>1</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Tipton, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Fred Scheerer</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Shaw</u>			14. NAME OF HUSBAND OR WIFE <u>Larry L.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Larry L. Kester</u>		ADDRESS <u>817 W. 3</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  <u>306</u>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Syphilitic Chronic Endocarditis</u>  ANTECEDENT CAUSES DUE TO (b) <u>Neurosyphilis-General Paresis</u> 4 years DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Fracture of Surgical Neck of Femur</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH  <u>029</u>	
19a. DATE OF OPERATION <u>12/26/48</u>		19b. MAJOR FINDINGS OF OPERATION <u>Fracture of Surgical Neck of Femur (Right Femur)</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Sedalia Pettis Mo.</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12 24 1948</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Spontaneous fracture Syphilis of bone</u>					
22. I hereby certify that I attended the deceased from <u>April 1, 1948</u> , to <u>Dec. 31, 1948</u> , that I last saw the deceased alive on <u>Dec. 31, 1948</u> , and that death occurred at <u>8:00a</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Print or title) <u>H. H. Houches M.D.</u>				23b. ADDRESS <u>Sedalia, Mo. Woodland Hospital &amp; Clinic</u>		23c. DATE SIGNED <u>12/31/48</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-3-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>			
DATE REC'D BY LOCAL REG. <u>1-3-49</u>		REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. Laughlin Bros.</u>		ADDRESS <u>519 So Ohio</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. \_\_\_\_\_

District File Number \_\_\_\_\_

Date Filed 1-20-49

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*K.P. G. Csary*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3153

P. O. Address Sedalia 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.

FILED JAN 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 393

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>	c. LENGTH OF STAY (in this place) <u>12 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Woodland Hosp.</u>		d. STREET ADDRESS (If rural, give location) <u>817 W 3<sup>rd</sup></u>	

3. NAME OF DECEASED (Type or Print) <u>Augusta Scheerer Kester</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 31, 1948</u>		
a. (First)	b. (Middle)	c. (Last)			

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 30, 1889</u>	9. AGE (In years last birthday) <u>59</u>	10. UNDER 1 YEAR Months <u>11</u> Days <u>1</u>	11. UNDER 1 HRS. Hours <u>1</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Tipton, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Fred Scheerer</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Shaw</u>	14. NAME OF HUSBAND OR WIFE <u>Larry L.</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OF NAME <u>Larry L. Kester</u>	ADDRESS <u>817 W. 3<sup>rd</sup></u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <u>4 yrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Syphilitic Chronic Endocarditis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Neurosyphilis - General Curious</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Treatment of Syphilitic neck of femur.</u>			

19a. DATE OF OPERATION <u>12/30/48</u>	19b. MAJOR FINDINGS OF OPERATION <u>Fracture of Surgical neck. Femur - (Right Femur)</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Sedalia Pettis Mo</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12 24 1948 ? m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Spontaneous fracture - Syphilis of bone</u>

22. I hereby certify that I attended the deceased from April 1, 1948, to 12/31, 1948, that I last saw the deceased - alive on 12/31, 1948, and that death occurred at 8:00P m., from the causes and on the date stated above.

23a. SIGNATURE <u>A. Crocker</u>	(Degree or title)	23b. ADDRESS <u>20. MO Woodland Hospital, Sedalia, Mo</u>	23c. DATE SIGNED <u>12/31/48</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1-3-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>	24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>
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DATE REC'D BY LOCAL REG. <u>1-3-49</u>	REGISTRAR'S SIGNATURE <u>Betty Yeager DeLong</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>McLaughlin Bros</u>	ADDRESS <u>Sedalia</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

VS FEB 8 1888

**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 .....  
Student Embalmer

Signed \_\_\_\_\_

*H. P. M. Lary*

Licensed Embalmer No. *2153*

P. O. Address *Sedalia 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.