

FILED JAN 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1663

BIRTH NO. _____ REG. DIST. NO. 164 PRIMARY REG. DIST. NO. 3032 Registrar's No. 5

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

1. PLACE OF DEATH a. COUNTY Johnson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lafayette	
b. CITY OR TOWN Warrensburg		c. CITY OR TOWN Mayview	
c. LENGTH OF STAY (in this place) 2 days		d. STREET ADDRESS Mayview	
d. FULL NAME OF HOSPITAL OR INSTITUTION Warrensburg Clinic		(If rural, give location)	
3. NAME OF DECEASED a. (First) Albert William Schowengardt (Type or Print) b. (Middle) c. (Last)			4. DATE OF DEATH Jan. 10 - 1949 (Month) (Day) (Year)
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 2-13-1876
9. AGE (In years last birthday) 72		10. MONTHS 11	11. DAYS 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Hopewell Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Henry Schowengardt	
13b. MOTHER'S MAIDEN NAME Louise Schowengardt		14. NAME OF HUSBAND OR WIFE Merwin Reuter Schowengardt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Albert Goetz		ADDRESS Mayview Mo.	
MEDICAL CERTIFICATION			
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion	
		INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
		DUPLICATE 3-4 months	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION H2	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-9, 1949, to 1-10, 1949, that I last saw the deceased alive on 1-10, 1949, and that death occurred at 8:00 P.M., from the causes and on the date stated above.			
23a. SIGNATURE R. Lee Cooper M.D.		23b. ADDRESS Warrensburg, Mo.	
23c. DATE SIGNED 1-17-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-13-1949	
24c. NAME OF CEMETERY OR CREMATORY Evangelical Cemetery		24d. LOCATION (City, town, or county) (State) Higginsville, Mo.	
DATE REC'D BY LOCAL REG. Jan. 17, 1949		REGISTRAR'S SIGNATURE Savannah Dentel Pike Roy	
25. FUNERAL DIRECTOR'S SIGNATURE H. J. Greger		ADDRESS Higginsville, Mo.	

JAN 26 1949

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 Ray F. Wiegner

Licensed Embalmer No. 2883

P. O. Address Higginsville 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.