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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Patten 1787
State File No. 1787

FILED FEB 1 1949

BIRTH NO. 49-002798 REG. DIST. NO. 184 PRIMARY REG. DIST. NO. 3032 Registrar's No. 126

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Linn</u>	
b. CITY OR TOWN <u>Brookfield</u>		c. CITY OR TOWN <u>Yellow Creek Twp</u>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McLarney Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>DALE</u> b. (Middle) <u>FRANCIS</u> c. (Last) <u>SCHREINER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan - 8 - 1949</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>()</u>	
8. DATE OF BIRTH <u>Jan - 2 - 49</u>		9. AGE (In years last birthday) <u>20</u>		if UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Brookfield Mo</u>	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME <u>Leo Schreiner</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Kemberger</u>		14. NAME OF HUSBAND OR WIFE	
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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)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Leo Schreiner Brookfield Mo</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary atelectasis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>2</u>	
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22. I hereby certify that I attended the deceased from Jan 8, 1949, to Jan 9, 1949, that I last saw the deceased alive on Jan 8, 1949, and that death occurred at 6:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. H. Patten, M.D.</u>		23b. ADDRESS <u>Brookfield Mo</u>		23c. DATE SIGNED <u>1-12-49</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan-10-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Michael Ben</u>	
				24d. LOCATION (City, town, or county) (State) <u>Brookfield Mo</u>	

DATE REC'D BY LOCAL REG. <u>1/15/49</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Will Funeral Home Brookfield Mo</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.