

FILED MAY 11 1949

STANDARD CERTIFICATE OF DEATH

State File No. 12010

12

BIRTH NO. 49-021588 REG. DIST. NO. 119 PRIMARY REG. DIST. NO. 4193 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Gasconade		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ Mo. b. COUNTY Gasconade	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hermann		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hermann,	
d. FULL NAME OF HOSPITAL OR INSTITUTION Workman Hospital		d. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED (Type or Print) a. (First) "UNNAMED BABY BOY" b. (Middle) _____ c. (Last) SCHMIDT			4. DATE OF DEATH (Month) (Day) (Year) April 25-1949		
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5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH 4-25-49		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Days Min. 1 25	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hermann, Mo		12. CITIZEN OF WHAT COUNTRY? US	
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13a. FATHER'S NAME Marvin Schmidt		13b. MOTHER'S MAIDEN NAME Darlene Saak		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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marvin Schmidt Hermann, Mo	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Premature - 6 mo gestation ANTECEDENT CAUSES Morbid 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 (hr. min) 1 hr. 25 min 776X	
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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)		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?	
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22. I hereby certify that I attended the deceased from 4-25, 1949, to 4-25, 1949, that I last saw the deceased alive on 9-25, 1949, and that death occurred at 8:30 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Cavell T. Shank MD		23b. ADDRESS Hermann, Mo.		23c. DATE SIGNED 4-26-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-26-49		24c. NAME OF CEMETERY OR CREMATORY Hermann City		24d. LOCATION (City, town, or county) (State) Hermann Mo	
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DATE REC'D BY LOCAL REG. 4/26/49		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hegos & Plummer Hermann, Mo	
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Date Filed
District File Number
MAY 10 1949
District Health Officer No. 9,
RECEIVED

STATEMENT BY LICENSED EMBALMER

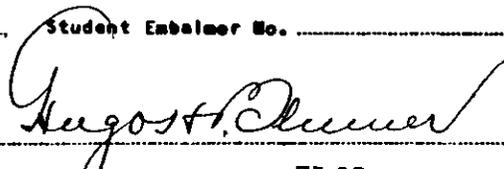
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Signed _____



Signed _____
Student Embalmer

Licensed Embalmer No. 3160

P. O. Address Hermann, 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.