

FILED MAY 18 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15140

BIRTH NO. _____		REG. DIST. NO. <u>53</u>		PRIMARY REG. DIST. NO. <u>3010</u>		Registrar's No. <u>135</u>		
1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cape Girardeau</u>		c. LENGTH OF STAY (In this place) <u>45 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>		/ <u>6</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>R. R. 2 road. 4 Miles west on Gordonville/</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u> b. (Middle) <u>K.</u> c. (Last) <u>SCHABING</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 11, 1949</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>October 4, 1889</u>		
9. AGE (In years last birthday) <u>59</u>		IF UNDER 1 YEAR Days <u>7</u>		IF UNDER 11 HRS. Hours <u>17</u>		IF UNDER 24 HRS. Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Perry County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>Barney Kohlfeld</u>			13b. MOTHER'S MAIDEN NAME <u>Katherine Wingerter</u>			14. NAME OF HUSBAND OR WIFE <u>Joseph Schabbing</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>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Leo Schabbing Cape Gir., Mo.</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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Subarachnoid hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> 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>330X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					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 <u>5/10, 1949</u> to <u>5/11, 1949</u> , that I last saw the deceased alive on <u>5/11, 1949</u> , and that death occurred at <u>7:30 p. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>J. H. Kern, M.D. (1)</u>				23b. ADDRESS <u>Cape Girardeau, Mo</u>		23c. DATE SIGNED <u>5/13/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 14, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ST. Mary's Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Cape Girardeau, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>5-13-1949</u>		REGISTRAR'S SIGNATURE <u>C. C. Summers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walther's Funeral Home</u>		ADDRESS <u>Cape Gir., Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

Dist. Health Officer No. 4  
Case File Number 549-65  
Date filed 5-16-49

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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.

Student .....  
Student Embalmer

Signed Virgil K. Welch

Licensed Embalmer No. 2102

P. O. Address Cape Guard

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.