

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22535**

FILED AUG 9 1949

BIRTH NO. _____ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **200**

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia		c. LENGTH OF STAY (If this place) 5 hrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION University (Clayes) Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Moberly RR #1	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Joseph c. (Last) Schumann		4. DATE OF DEATH (Month) (Day) (Year) 8-5-49	
5. SEX M	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED, WIDOWED DIVORCED (Specify) Never	8. DATE OF BIRTH 12-16-33
9. AGE (In years last birthday) 15 yea.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Moberly, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Frank Schumann		13b. MOTHER'S MAIDEN NAME Edna Trauer	
14. NAME OF HUSBAND OR WIFE		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.		17. INFORMANT'S SIGNATURE OR NAME Frank Schumann ADDRESS Moberly Mo	
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) Bulbar Poliomyelitis 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT (Specify) SUICIDE HOMICIDE	
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) m.		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 5 Aug, 1949 to 5 Aug, 1949 , that I last saw the deceased alive on 5 Aug, 1949 , and that death occurred at 7:50 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (J.) Virgil R. May (Degree or title) MD		23b. ADDRESS University Hospital	
23c. DATE SIGNED 8-6-49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Aug 7th 1949		24c. NAME OF CEMETERY OR CREMATORY St Mary's	
24d. LOCATION (City, town, or county) (State) Moberly Mo		DATE REC'D BY LOCAL REG. Aug 6 1949	
REGISTRAR'S SIGNATURE Mrs R E Palmer		31	
25. FUNERAL DIRECTOR'S SIGNATURE Mahan and Son ADDRESS Moberly Mo			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED AUG 8 1919
District Health Officer No. 9,
District File Number

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 Frank B. D. Witt

Licensed Embalmer No. 3021

P. O. Address Moberly, 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.