

FILED JUL 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23265**

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

46
8

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>5557</u>		Registrar's No. <u>74</u>	
1. PLACE OF DEATH a. COUNTY Howell County				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Howell			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN "RURAL" Howell Twp.)		c. LENGTH OF STAY (in this place) 13 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN "RURAL" South Fork Twp.			
d. FULL NAME OF HOSPITAL OR INSTITUTION Howell County Farm				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) Forrest		b. (Middle) (none)		c. (Last) Schoffler		4. DATE OF DEATH (Month) (Day) (Year) June 7, 1949	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) unknown		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 55 Aprx.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) 9	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Schoffler		13b. MOTHER'S MAIDEN NAME Mary		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)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS E.E. Dix, Supt. Howell County Farm			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 490X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 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 <u>June 7, 1949</u> , to <u>June 7, 1949</u> , that I last saw the deceased alive on <u>June 7, 1949</u> , and that death occurred at <u>5-00 Pm.</u> , from the causes and on the date stated above.							
23. SIGNATURE Robert A. ... (Degree or title)				23b. ADDRESS West Plains, Mo		23c. DATE SIGNED July 49	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE June 7, 1949		24c. NAME OF CEMETERY OR CREMATORY McElmurry Cem.		24d. LOCATION (City, town, or county) (State) "Rural" So. Fork Twp. Mo.	
DATE REC'D BY LOCAL REG. 7-5-49		REGISTRAR'S SIGNATURE Beatrice Cook		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mayme C. Hornburgh West Plains, MO.			

RECEIVED 7-11-49
District Health Officer No. 5,
District File No. 749477
Date Filed 7-14-49

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 _____

working under my personal supervision. _____
Student Embalmer No. _____

Student _____ 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.

Not Embalmed