

FILED AUG 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHDR PA 26577
State File No. 26577

BIRTH NO. _____		REG. DIST. NO. <u>116</u>		PRIMARY REG. DIST. NO. <u>5432</u>		Registrar's No. <u>32</u>	
1. PLACE OF DEATH a. COUNTY <u>FRANKLIN - Stanton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>FRANKLIN</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL-McKAMEL</u>		c. LENGTH OF STAY (in this place) <u>10 mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL-BOEUF</u>		36	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>MILLER NURSING HOME</u>				d. STREET ADDRESS (If rural, give location) <u>5 Miles South of BERGER</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u> b. (Middle) <u>MATILDA</u> c. (Last) <u>SCHMIDT</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>8-14-1949</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>JUNE 12 1863</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEKEEPER</u>		9. AGE (In years last birthday) <u>86 2 2</u>		10. IF UNDER 1 YEAR Months Days Hours 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 <u>HOUSEKEEPER</u>		11. BIRTHPLACE (State or foreign country) TOWN <u>UNKNOWN IOWA</u>	
11. BIRTHPLACE (State or foreign country) TOWN <u>UNKNOWN IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>PETER WAGNER</u>			
13a. FATHER'S NAME <u>PETER WAGNER</u>		13b. MOTHER'S MAIDEN NAME <u>LADIA WAGNER</u>		14. NAME OF HUSBAND OR WIFE <u>REV. W. K. M. Schmidt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) (If yes, give way or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Joe Guss Berger 75</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Infirmities of old age</u>		DUPLICATE OF (a) <u>7 1/2</u>					years
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					DUPLICATE OF (a) <u>7 1/2</u>
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUPLICATE OF (a) <u>7 1/2</u>					DUPLICATE OF (a) <u>7 1/2</u>
DUPLICATE OF (a) <u>7 1/2</u>		DUPLICATE OF (a) <u>7 1/2</u>					DUPLICATE OF (a) <u>7 1/2</u>
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.					DUPLICATE OF (a) <u>7 1/2</u>
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)	
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)	
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>Jan</u> , 19 <u>69</u> , to <u>8-14</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8-10</u> , 19 <u>49</u> , and that death occurred at <u>12:30 pm</u> from the causes and on the date stated above.							
23a. SIGNATURE <u>Ch. Carter M.D.</u> (Degree or title)			23b. ADDRESS <u>100 W. Main St. Sullivan</u>			23c. DATE SIGNED <u>8-14-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-16-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cemetery</u>		24d. LOCATION (City, town, or township) (State) <u>Berger Mo 670</u>	
DATE REC'D BY LOCAL REG. <u>8-15-49</u>		REGISTRAR'S SIGNATURE <u>Ch. Carter 99</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Paul H. Bremer Berger Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
AUG 22 1949
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 *Herman Blumer*

Licensed Embalmer No. *528*

P. O. Address *Berger 277 D*

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.