

FILED NOV 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **33508**

BIRTH NO. _____		REG. DIST. NO. <u>118</u>		PRIMARY REG. DIST. NO. <u>5440</u>		Registrar's No. <u>35</u>	
1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Clay twns.</u>		c. LENGTH OF STAY (in this place) <u>30 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Clay township</u>		33	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Carie Francis</u>		b. (Middle) <u>Drewell</u>		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>10-22-1949</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>April 8-1873</u>		9. AGE (In years last birthday) <u>77 yrs</u>	
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>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Henry Schaepperkoetter</u>		13b. MOTHER'S MAIDEN NAME <u>Amelia Ahrens</u>		14. NAME OF HUSBAND OR WIFE <u>Wm. Drewell</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>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Wm. Drewell</u>		ADDRESS <u>Bland.</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 INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>myocarditis</u>				DUE TO (b) <u>Pneumatism</u>			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>✓</u>				4222			
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 <u>✓</u>		20. AUTOPSY? YES ☐ NO ☒			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>✓</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>✓</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>✓</u>		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? <u>✓</u>			
22. I hereby certify that I attended the deceased from <u>1-1</u> , 19 <u>48</u> , to <u>10-22</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>10-22</u> , 19 <u>49</u> , and that death occurred at <u>3:15 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. A. Bunge M.D.</u>				23b. ADDRESS <u>Bland Mo</u>		23c. DATE SIGNED <u>10-24-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 24-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Gasconade County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-25-49</u>		REGISTRAR'S SIGNATURE <u>Norothy Dackman</u>		FURNERAL DIRECTOR'S SIGNATURE <u>Sassmann's Funeral Service-Bland</u>		ADDRESS <u>Chas. Sassmann</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

District File Number _____
District Health Officer No. 9,
NOV 5 1949 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 _____

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

Signed _____
Student Embalmer

Signed Chester Sassman

Licensed Embalmer No. 4178

P. O. Address Bland

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.'