

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36574**

FILED DEC 2 1949

Registrar's No. **78**

BIRTH NO. _____		REG. DIST. NO. <b>52</b>		PRIMARY REG. DIST. NO. <b>5182</b>		Registrar's No. <b>78</b>			
1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b>				b. COUNTY <b>Cape Girardeau</b>	
b. CITY (If outside corporate limits, give township) <b>Neelys Landing</b>		2. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) <b>Neelys Landing</b>		d. STREET ADDRESS (If rural, give location) <b>Rural Shamrock, Mo.</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Neelys Landing, Mo.</b>				3. NAME OF DECEASED a. (First) <b>J</b>				b. (Middle) <b>Frank</b>	
c. (Last) <b>Schenimann</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 22, 1949</b>		5. SEX <b>Male</b>			
6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Sept. 17, 1875</b>		9. AGE (In years last birthday) <b>74</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Neelys Landing, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Henry Schenimann</b>			13b. MOTHER'S MAIDEN NAME <b>May Massay</b>			14. NAME OF HUSBAND OR WIFE <b>Amanda Schenimann</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <b>Amanda Schenimann</b>					
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac Decompensation</b>  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. <b>Prostatic Hypertrophy</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>  <b>4343</b>			
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) (Min.)		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 <b>May 1, 1949</b> , to <b>11-22, 1949</b> , that I last saw the deceased alive on <b>11-22, 1949</b> , and that death occurred at <b>9 P.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>C.F. McDonald, M.D.O.</b>				23b. ADDRESS <b>Jackson, Mo.</b>		23c. DATE SIGNED <b>11-25-49</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>11/25/1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		24d. LOCATION (City, town, or county) (State) <b>4 miles East of Jackson, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>Nov 25-49</b>		REGISTRAR'S SIGNATURE <b>D.G. Lubbo</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Loran</b>					
				ADDRESS <b>Jackson, Mo.</b>					

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

RECEIVED 11-28-49  
District Health Officer No. 4  
District File Number 1149-154  
Date Filed \_\_\_\_\_

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. ....

Signed Gene C. Crawford

Signed.....  
Student Embalmer

Licensed Embalmer No. 4327

P. O. Address Jackson, 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.