

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43428**

FILED JAN 6 1950

BIRTH NO. _____ REG. DIST. NO. **337** PRIMARY REG. DIST. NO. **6139** Registrar's No. **109**

1. PLACE OF DEATH a. COUNTY Shelby		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Shelby	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Black Creek	c. LENGTH OF STAY (in this place) 1	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION Pleasant Hill Rest Home		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) BENJAMIN M. Schilling	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Dec. 20 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH No Record	9. AGE (In years last birthday) 80?	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) No Record	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME No record	13b. MOTHER'S MAIDEN NAME No Record	14. NAME OF HUSBAND OR WIFE na.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. L	17. INFORMANT'S SIGNATURE OR NAME Randall Mahaffy ADDRESS Shelbyville Mo
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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.	MEDICAL CERTIFICATION acute myocardial		INTERVAL BETWEEN ONSET AND DEATH 17 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cause of death not determined		
	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 type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **Dec 20, 1949**, to **Dec 28, 1949**, that I last saw the deceased alive on **Dec 20, 1949**, and that death occurred at **4 P.M.** m., from the causes and on the date stated above.

23a. SIGNATURE P.C. Akeley M.D. (Degree or title)	23b. ADDRESS Shelbyville Mo	23c. DATE SIGNED Dec 23-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec 22-49	24c. NAME OF CEMETERY OR CREMATORY Prairie View Cemetery	24d. LOCATION (City, town, or county) (State) Shelby County Mo
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DATE REC'D BY LOCAL REG. Dec-28-49	REGISTRAR'S SIGNATURE Ada Garrison	25. FUNERAL DIRECTOR'S SIGNATURE E.P. Thompson ADDRESS Shelbyville Mo
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

102
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956

JAN 1 1950
RECEIVED
District Health Officer No.
District File Number 1-58-2
Date Filed JAN 1 1950

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 _____

Myself

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *E. P. Thompson*

Licensed Embalmer No. 1632

P. O. Address Shelbyville, 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.