

FILED JAN 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH421
State File No.

1. PLACE OF DEATH
a. COUNTY *Callaway*

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE *Mo* b. COUNTY *Warren*

b. CITY (If outside corporate limits, write RURAL and give township) *Fulton* c. LENGTH OF STAY (in this place) *13 yrs 9 2 mos*

c. CITY (If outside corporate limits, write RURAL and give township) *Pandolton*

d. FULL NAME OF HOSPITAL OR INSTITUTION *State Hospital MoT* d. STREET ADDRESS (If rural, give location) *unk*

3. NAME OF DECEASED (Type or Print)
a. (First) *Mary* b. (Middle) *Remschner* c. (Last) *Remschner*

4. DATE OF DEATH (Month) (Day) (Year) *1-2-50*

5. SEX *female* 6. COLOR OR RACE *white* 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) *Single* 8. DATE OF BIRTH *Unknown* 9. AGE (In years last birthday) *67* IF UNDER 1 YEAR Months *-* Days *-* IF UNDER 4 HRS. Hours *-* Min. *-*

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Have work* 10b. KIND OF BUSINESS OR INDUSTRY *unk* 11. BIRTHPLACE (State or foreign country) *Mo* 12. CITIZEN OF WHAT COUNTRY? *U.S.A*

13a. FATHER'S NAME *Henry Remschner* 13b. MOTHER'S MAIDEN NAME *Anna apt* 14. NAME OF HUSBAND OR WIFE *-*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) *unk* (If yes, give war or dates of service) *unk* 16. SOCIAL SECURITY NO. *unk* 17. INFORMANT'S SIGNATURE OR NAME *State Hospital Records* ADDRESS *Fulton*

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) *Chr. Mys Carditis*
*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
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) *unk*
DUE TO (c) *unk*
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. *High Static Pneumonia*

19a. DATE OF OPERATION *unk* 19b. MAJOR FINDINGS OF OPERATION *unk* 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) *unk* 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) *unk* 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) *Fulton, Mo*

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) *unk* 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? *unk*

22. I hereby certify that I attended the deceased from *31 July, 1947, to 2 Jan, 1950*, that I last saw the deceased alive on *1 Jan, 1950*, and that death occurred at *6 a. m.*, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) *G.S. Wardell M.D.* 23b. ADDRESS *Fulton, Mo* 23c. DATE SIGNED *2 Jan 1950*

24a. BURIAL, CREMATION, REMOVAL (Specify) *Removed* 24b. DATE *1-4-50* 24c. NAME OF CEMETERY OR CREMATORY *Anatomical Calloway Columbian* 24d. LOCATION (City, town, or county) (State) *unk Mo*

DATE REC'D BY LOCAL REG. *Jan 4-1950* REGISTRAR'S SIGNATURE *Martha Lawrence* 426 25. FUNERAL DIRECTOR'S SIGNATURE *J. B. Roberts* ADDRESS *Columbian Mo*

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

RECEIVED
JAN 16 1950
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

working under my personal supervision.

Student Embalmer No.....

Signed.....

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.