No. 300
10.48

FILED JUL 8 1950

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 22469

BIRTH NO. _____ REG. DIST. NO. 336 PRIMARY REG. DIST. NO. 6125 Registrar's No. 69

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

**1. PLACE OF DEATH**
a. COUNTY: SHANNON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL - CASTO No 2
c. LENGTH OF STAY (In this place): 34 YRS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 12 MI. EAST SUMMERSVILLE

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: MO
b. COUNTY: SHANNON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL - CASTO No 2 1010
d. STREET ADDRESS (If rural, give location): 12 MI. EAST SUMMERSVILLE

**3. NAME OF DECEASED** (Type or Print)
a. (First): LILLY
b. (Middle): MAY
c. (Last): SCHWEIGHAUSER

**4. DATE OF DEATH** (Month) (Day) (Year): JAN 1 1950

**5. SEX**: F
**6. COLOR OR RACE**: W
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): MARRIED
**8. DATE OF BIRTH**: JULY 1 1875
**9. AGE** (In years last birthday): 74 — IF UNDER 1 YEAR: Months 6, Days — IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE
**10b. KIND OF BUSINESS OR INDUSTRY**: HOUSEWIFE
**11. BIRTHPLACE** (State or foreign country): PIKE COUNTY MO
**12. CITIZEN OF WHAT COUNTRY?**: AM

**13a. FATHER'S NAME**: HAULET
**13b. MOTHER'S MAIDEN NAME**: NOT KNOWN
**14. NAME OF HUSBAND OR WIFE**: FRANK F SCHWEIGHAUSER

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No (If yes, give war or dates of service)
**16. SOCIAL SECURITY NO.**:
**17. INFORMANT'S SIGNATURE OR NAME** ADDRESS: FRANK SCHWEIGHAUSER SUMMERSVILLE MO

**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**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) [illegible]

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
(b) Coronary Thrombosis
DUE TO (c) Chronic Valvular Disease

INTERVAL BETWEEN ONSET AND DEATH

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 ☐ NO ☒

**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) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* DEC 2, 1949, *to* JAN 1, 1950, *that I last saw the deceased alive on* DEC 31, 1949, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): Dr Lavere Hempton DO 2
**23b. ADDRESS**: Summersville
**23c. DATE SIGNED**: Jan 10

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE**: Jan 2
**24c. NAME OF CEMETERY OR CREMATORY**: FLAT WOODS
**24d. LOCATION** (City, town, or county) (State): SHANNON

**DATE REC'D BY LOCAL REG.**: 6/24/50
**REGISTRAR'S SIGNATURE**: L. L. Rollins per W. Rollins 306
**25. FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: NONE

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED JUN 29 1950
District Health Office No. 6,

District File Number _____

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.....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed.....

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.