

FILED JUL 18 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23121**  
Registrar's No. **18**

BIRTH NO. _____		REG. DIST. NO. <b>84</b>		PRIMARY REG. DIST. NO. <b>5320</b>		State File No. <b>23121</b>		Registrar's No. <b>18</b>		
1. PLACE OF DEATH a. COUNTY <b>COOPER</b>					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>COOPER</b>					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>PALESTINE (RURAL)</b> ) (township)			c. LENGTH OF STAY (in this place) <b>71 yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>PALESTINE (RURAL)</b>			TOWN <b>PALESTINE (RURAL)</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1 MILE SOUTH OF SPEED</b>					d. STREET ADDRESS (If rural, give location) <b>1 MILE SOUTH OF SPEED</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>MRS</b> b. (Middle) <b>WILHELMINA</b> c. (Last) <b>SCHWITZKY</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 30-1950</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WESTPHALIA - GERMANY</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>FREDERICK JOHNMAYER</b>			13b. MOTHER'S MAIDEN NAME <b>CHARLOTTE</b>		14. NAME OF HUSBAND OR WIFE <b>ROBERT SCHWITZKY</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>HERMAN SCHWITZKY - BOONVILLE MO</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, asphyxia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>HOBAR PNEUMONIA</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>CHRONIC NEPHRITIS</b> DUE TO (c) <b>CHRONIC ENDOCARDITIS</b> 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>VASCULAR HYPERTENSION</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>5 Mo.</b> <b>5 Mo.</b> <b>592X</b>	
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION <b>NONE</b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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>JAN. 6, 1950</b> , to <b>JUNE 30, 1950</b> , that I last saw the deceased alive on <b>JUNE 30, 1950</b> and that death occurred at <b>1:19 p.m.</b> , from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) <b>Dr. James A. Carruth, D.C.</b>					23b. ADDRESS <b>BUNCEYTON, MO</b>			23c. DATE SIGNED <b>6-30-50</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>JULY 2-1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>BILLINGSVILLE CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>BILLINGSVILLE MO.</b>				
DATE REC'D BY LOCAL REG <b>July 16-50</b>		REGISTRAR'S SIGNATURE <b>Nellie Mullett</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>STEGNER FUNERAL HOME-BOONVILLE MO.</b>					

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

RECEIVED *2/2*

DISTRICT HEALTH OFFICE No. 3

District File Number .....

Date Filed 7-17-50

SEP 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

Student Embalmer No. ....

working under my personal supervision.

Signed

*James W. Segner*

Signed.....  
Student Embalmer

Licensed Embalmer No. 2780

P. O. Address BOONVILLE \*\* 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.