

FILED MAY 19 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16114

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 459-B

1396  
4

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

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>GREENE</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>CHRISTIAN</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>SPRINGFIELD</u> |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><u>BILLINGS</u> <u>0220</u>   |  |
| c. LENGTH OF STAY (in this place)<br><u>12 DAYS</u>  |  | d. STREET ADDRESS (If rural, give location)<br><u>NO STREET ADDRESS</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>BARBER REST HOME</u>                         |  |   |  |

|   |                       |                           |  |
|---|-----------------------|---------------------------|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>FERD</u> | b. (Middle) <u>E.</u> | c. (Last) <u>SCHAEFER</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>MAY 7 1952</u> |
|---|-----------------------|---------------------------|--|

|                    |                               |  |   |   |                         |                        |                         |                        |
|--------------------|-------------------------------|--|---|---|-------------------------|------------------------|-------------------------|------------------------|
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>NEVER MARRIED</u> | 8. DATE OF BIRTH<br><u>JUNE 22-1874</u> | 9. AGE (In years last birthday) <u>77</u> | 10. UNDER 1 YEAR Months | 11. UNDER 24 HRS. Days | 12. UNDER 24 HRS. Hours | 13. UNDER 24 HRS. Min. |
|--------------------|-------------------------------|--|---|---|-------------------------|------------------------|-------------------------|------------------------|

|  |   |   |   |
|--|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HARNESSE MAKER</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>RETIRED</u> | 11. BIRTHPLACE (State or foreign country)<br><u>SPARTA - ILLINOIS</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |
|--|---|---|---|

|                                      |   |   |
|--------------------------------------|---|---|
| 13a. FATHER'S NAME<br><u>UNKNOWN</u> | 13b. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u> | 14. NAME OF HUSBAND OR WIFE<br><u>NEVER MARRIED</u> |
|--------------------------------------|---|---|

|   |  |   |
|---|--|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u> | 16. SOCIAL SECURITY NO.<br><u>NONE</u> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>LEO SMITH BILLINGS, MO.</u> |
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|   |   |  |  |                |
|---|---|--|--|----------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 YRS</u> |                |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Generalized Arteriosclerosis</u> |  |  | <u>10 YRS.</u> |
|   | DUE TO (c) <u>Brachialis Hypertrophy</u>  |  |  | <u>1 YEAR.</u> |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |  |                |

|                        |   |   |
|------------------------|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION<br><u>4200</u> | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|---|---|

|   |  |   |
|---|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)<br><u>None</u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br><u>BILLINGS</u> <u>MO.</u> |
|---|--|---|

|  |  |                            |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><u>None</u> | 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 April 1, 1952, to May 7, 1952, that I last saw the deceased alive on May 6, 1952, and that death occurred at 1:28 P.M., from the causes and on the date stated above.

|   |  |                                   |
|---|--|-----------------------------------|
| 23a. SIGNATURE (Degree or title)<br><u>William J. Dault, M.D.</u> | 23b. ADDRESS<br><u>609 Cherry - Springfield, Mo.</u> | 23c. DATE SIGNED<br><u>5/7/52</u> |
|---|--|-----------------------------------|

|  |                                 |  |  |
|--|---------------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u> | 24b. DATE<br><u>MAY 10-1952</u> | 24c. NAME OF CEMETERY OR CREMATORY<br><u>ST. JOSEPH'S CEMETERY</u> | 24d. LOCATION (City, town, or county) (State)<br><u>BILLINGS MO.</u> |
|--|---------------------------------|--|--|

|  |   |  |
|--|---|--|
| DATE REC'D BY LOCAL REG.<br><u>5-13-52</u> | REGISTRAR'S SIGNATURE<br><u>James R. Amos, M.D.</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>John Alan Harris, Clever, Mo.</u> |
|--|---|--|

(Licensed Embalmer's Statement on Reverse Side)

**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 John Dean Harris

Licensed Embalmer No. 4390

P. O. Address Cleveland, 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.