

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19232**

JUN 23 1952

0013
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>224</u>			
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>					
b. CITY OR TOWN <u>Kirkaville</u>		c. LENGTH OF STAY (in this place) <u>2 1/2 mo.</u>		c. CITY OR TOWN <u>Kirkaville, Mo.</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Community Nursing Home # 2</u>				d. STREET ADDRESS (If rural, give location) <u>301 S. High St</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Theodore</u>			b. (Middle) <u>Walter</u>		c. (Last) <u>Schultz</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 15 1952</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 26, 1873</u>	9. AGE (in years last birthday) <u>79</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Oskaloosa Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Fred Schultz</u>			13b. MOTHER'S MAIDEN NAME <u>Christianna Lessman</u>		14. NAME OF HUSBAND OR WIFE <u>Florence C. Schultz</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME <u>Ray H. Schultz</u>				ADDRESS <u>301 S. High St.</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Renal Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Nephrosclerosis</u> DUE TO (c) <u>14 y peripheral arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic gangrene</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 dca</u> <u>48 hrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Right foot.</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? <u>446X</u>					
22. I hereby certify that I attended the deceased from <u>March 29, 1952</u> , to <u>June 15, 1952</u> , that I last saw the deceased alive on <u>June 15, 1952</u> , and that death occurred at <u>11:30 PM</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>David W. Bono M.D.</u>				23b. ADDRESS <u>Birtsville, Mo.</u>			23c. DATE SIGNED <u>6-15-52</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6/17/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		24d. LOCATION (City, town, or county) (State) <u>Macon, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>6-20-52</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Skinner</u> ADDRESS <u>Macon, Mo.</u>					

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 Thos. L. Roth

Licensed Embalmer No. 4552

P. O. Address Macou, 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.