

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. **FILED MAR 23 1954** REG. DIST. NO. **178** PRIMARY REG. DIST. NO. **4286** Registrar's No. **25**

560
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Lewis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lewis	
b. CITY (If outside corporate limits, write RURAL and give township) LaGrange		c. CITY (If outside corporate limits, write RURAL and give township) 0560	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) No St. Address	
d. FULL NAME OF HOSPITAL OR INSTITUTION At Home - No St. Address			

3. NAME OF DECEASED (Type or Print)	a. (First) Daisy	b. (Middle) Oneida	c. (Last) Schofield	4. DATE OF DEATH (Month) (Day) (Year) JAN. 29-1954
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH MARCH 3, 1898	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY House Keeping	11. BIRTHPLACE (City and State or Foreign Country) Nelsonville, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Washington Dabney	13b. MOTHER'S MAIDEN NAME FANNY GRANT	14. NAME OF HUSBAND OR WIFE HENRY Schofield
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Carl Schofield	ADDRESS LaGrange, Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH 2 YRS
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRIGHT'S DISEASE		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 593X			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **1/15**, 1954 to **1/29**, 1954, that I last saw the deceased alive on **1/29**, 1954, and that death occurred at **9:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. F. Jennings M.D.	23b. ADDRESS LaGrange, Mo.	23c. DATE SIGNED 2/2/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb 1, 1954	24c. NAME OF CEMETERY OR CREMATORY River View	24d. LOCATION (City, town, or county) (State) LaGrange, Mo.
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DATE REC'D BY LOCAL REG. 3-17-54	REGISTRAR'S SIGNATURE P. W. Jennings, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE J. Kenneth Bailey	ADDRESS LaGrange, Mo.
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10 28 1946

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 J. Kenneth Bailey
Licensed Embalmer No. 4248

P. O. Address La Grange, Ill.

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.