

2965754
FILED NOV 5 - 1954

STANDARD CERTIFICATE OF DEATH

State File No. **33756**

BIRTH NO. _____ REG. DIST. NO. **144** PRIMARY REG. DIST. NO. **4234** Registrar's No. **54**

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

1. PLACE OF DEATH a. COUNTY Iron			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Washington		
b. CITY (If outside corporate limits, write RURAL and give township) Chronton		c. LENGTH OF STAY (In this place) 2 hr	c. CITY OR TOWN Rural		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary of Ozark Hosp.			e. STREET ADDRESS (If rural, give location) Near Peter's		
3. NAME OF DECEASED (Type or Print) a. (First) Lester		b. (Middle) Wayne	c. (Last) Schoener	4. DATE OF DEATH (Month) (Day) (Year) Oct. 4 1954	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH May 29 1954	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Chronton Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Lester E. Schoener		13b. MOTHER'S MAIDEN NAME Mary Ann Laramore	14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS		

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) meningitis following		INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (c) stating the underlying cause last. DUE TO (b) Verruis throat infection		
		DUE TO (c)		
		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 3403		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)	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 **Pet's** **1954**, to **Oct. 4, 1954**, that I last saw the deceased alive on **Oct. 3, 1954**, and that death occurred at **8 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Name or title) L. F. Caldwell M.D.		23b. ADDRESS Peters Mo.	23c. DATE SIGNED 10/4/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-6-54	24c. NAME OF CEMETERY OR CREMATORY Balderson E. Am.	24d. LOCATION (City, town, or county) (State) Washington Co. Mo.	
DATE REC'D BY LOCAL REG. 11/3/54	REGISTRAR'S SIGNATURE Mrs. Aris Jones	25. FUNERAL DIRECTOR'S SIGNATURE Mrs. Luther Sparks	ADDRESS Peters	

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.....
Signature of Student Embalmer

Signed *Murphy Sparks*.....
Licensed Embalmer No. *4236*
P. O. Address *Hot River, C.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.