

FILED DEC 7 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36893**

BIRTH NO. _____ REG. DIST. NO. **77** PRIMARY REG. DIST. NO. **3016** Registrar's No. **321**

1. PLACE OF DEATH a. COUNTY COLE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY OSAGE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFFERSON CITY		c. CITY OR TOWN LINN	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) 3 da.		e. STREET ADDRESS (If rural, give location) R.F.D.	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Chas. E. Still Osteopathic			

3. NAME OF DECEASED (Type or Print)	a. (First) ANNA	b. (Middle) CAROLINE	c. (Last) SCHMIDT	4. DATE OF DEATH (Month) (Day) (Year) Nov. 27-1954
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Nov. 24--1876	9. AGE (In years last birthday) 78	10 UNDER 1 YEAR 3	11 UNDER 1 HR. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Germany	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Paul Bossaller	13b. MOTHER'S MAIDEN NAME Caroline Krautwine	14. NAME OF HUSBAND OR WIFE Fred Schmidt (dec)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Clarence Schmidt	ADDRESS Linn MO.R.D.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage		
	DUE TO (c) Hypertension		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 **Oct 1, 1954**, to **Nov 27, 1954**, that I last saw the deceased alive on **Nov 27, 1954**, and that death occurred at **10:30 a.m.**, from the causes and on the date stated above.

22a. SIGNATURE Thomas W. Baldwin (Degree or title) D.O.	22b. ADDRESS Linn, Mo.	22c. DATE SIGNED 11/29/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/30/54	24c. NAME OF CEMETERY OR CREMATORY Ryors cemetery	24d. LOCATION (City, town, or county) (State) Linn Mo R.D.
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DATE REC'D BY LOCAL REG Nov 29-1954	REGISTRAR'S SIGNATURE R.P. Harrison	25. FUNERAL DIRECTOR'S SIGNATURE Clayton Mator	ADDRESS Linn MO
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

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 *Vernon M. Maston*

Licensed Embalmer No. *4125*

P. O. Address *Levin M.*

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.