

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

955

State File No. ....

FILED FEB 2 - 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 132 PRIMARY REG. DIST. NO. 3021 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY <b>Grundy</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Illinois</b> b. COUNTY <b>Rock Island</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Trenton</b>		c. LENGTH OF STAY (If in this place) <b>0</b> <b>5</b> HRS.	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Wright Memorial Hosp.</b>		f. STREET ADDRESS (If rural, give location) <b>520 22nd Street</b> <u>81208</u>	

3. NAME OF DECEASED (Type or Print) <b>Oma</b>	a. (First)	b. (Middle) <b>May</b>	c. (Last) <b>Schuett</b>	4. DATE OF DEATH <b>Jan. 5, 1955</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>May 2, 1878</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>homemaking</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Hampton, Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Adams</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Ann Daniels</b>	14. NAME OF HUSBAND OR WIFE <b>Fred Schuett</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>331-07-2340</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Bessie Walsh</b>	ADDRESS <b>Rock Island, Ill.</b>
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Generalized Arteriosclerosis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c)	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>447X</b>	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 Jan. 5, 1955, to Jan 5, 1955, that I last saw the deceased alive on Jan 5, 1955, and that death occurred at 6:45 p. m., from the causes and on the date stated above.

23a. SIGNATURE <b>Joseph M. Quisio M.D.</b>	(Degree or title)	23b. ADDRESS <b>Trenton, Mo.</b>	23c. DATE SIGNED <b>Jan. 6, 1955</b>
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24a. BURIAL-CREMA-TION-REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>1/6/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Knox Mortuary</b>	24d. LOCATION (City, town, or county) (State) <b>Rock Island, Ill.</b>
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DATE REC'D BY LOCAL REG. <b>1/6/55</b>	REGISTRAR'S SIGNATURE <b>Juene Fair</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Gipson Funeral Home</b>	ADDRESS <b>Trenton, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

1943

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 *Leo H. Whitaker*

Licensed Embalmer No. *478*

P. O. Address *Trenton*

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.