

FILED SEP 12 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26815

BIRTH NO. _____		REG. DIST. NO. <u>174</u>		PRIMARY REG. DIST. NO. <u>3035</u>		Registrar's No. <u>83</u>	
1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lexington</u>		c. LENGTH OF STAY (in this place) <u>8 days</u>		c. CITY OR TOWN <u>Lexington</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Lexington Memorial Hospital</u>				STREET ADDRESS (If rural, give location) <u>1501 Lafayette St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Claus</u>			b. (Middle) <u>Henry</u>		c. (Last) <u>Schroeder</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 30, 1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>August 4, 1886</u>	9. AGE (In years last birthday) <u>69</u>	10. UNDER 1 YEAR Months <u>0</u> Days <u>26</u>	11. UNDER 12 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Concordia, Missouri.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Henry Schroeder</u>			13b. MOTHER'S MAIDEN NAME <u>Marie Freitag</u>		14. NAME OF HUSBAND OR WIFE <u>Ida Kroencke</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. <u>_____</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ida Schroeder, Lexington, Mo.</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>Cerebrovascular accident</u>  ANTECEDENT CAUSES DUE TO (b) <u>generalized arteriosclerosis 9 days</u> DUE TO (c) <u>essential hypertension 5 years</u>  Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331 X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <u>8/21</u> , 19 <u>55</u> to <u>8/30</u> , 19 <u>55</u> that I last saw the deceased alive on <u>8/29</u> , 19 <u>55</u> , and that death occurred at <u>4:40 A.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Ralph W. Bailey M.D.</u>				23b. ADDRESS <u>Lexington</u>		23c. DATE SIGNED <u>8/30/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>September 1, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Machpelah</u>		24d. LOCATION (City, town, or county) (State) <u>Lexington, Missouri.</u>	
DATE REC'D BY LOCAL REG. <u>8-31-55</u>		REGISTRAR'S SIGNATURE <u>M. M. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>...</u>		ADDRESS	

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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.....  
*L. M. Y. Leav*

Licensed Embalmer No.....  
*29*

P. O. Address.....  
*Bellevue, Ind.*

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.