

FILED DEC 5 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **36470**

BIRTH NO. _____		REG. DIST. NO. <b>116</b>		PRIMARY REG. DIST. NO. <b>3020</b>		Registrar's No. <b>12</b>			
1. PLACE OF DEATH a. COUNTY <b>FRANKLIN</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>GASCONADE</b>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>WASHINGTON</b>		c. LENGTH OF STAY (If this place) <b>10 DAYS</b>		c. CITY OR TOWN <b>HERMANN</b>		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>ST. FRANCIS HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>Y Y W. Sixth St 037 1/2</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>JACOB</b> b. (Middle) <b>Schannuth</b> c. (Last) <b>Schannuth</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>DEC 2 - 1955</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>MARCH-15-1878</b>			
9. AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR <input checked="" type="checkbox"/>		IF UNDER 1 YEAR <input checked="" type="checkbox"/>		IF UNDER 1 YEAR <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>ELNSBOURG Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13a. FATHER'S NAME <b>JACOB Schannuth</b>			13b. MOTHER'S MAIDEN NAME <b>JULIA HOG</b>			14. NAME OF HUSBAND OR WIFE <b>EMMA Schannuth</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Wm KARL McKITTRICK Mo</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CEREBRAL THROMBOSIS</b>								<b>1 1/2 hr</b>	
* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) _____					
				DUE TO (c) <b>332XF</b>					
II. OTHER SIGNIFICANT CONDITIONS				<b>INTERTROCHANTERIC FRACTURE LEFT HIP</b>					
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"/>	
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) (Min)		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 <b>11-21, 1955</b> , to <b>12-2, 1955</b> that I last saw the deceased alive on <b>12-1, 1955</b> , and that death occurred at <b>1:35 A.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>George M. Workman M.D.</b>					23b. ADDRESS <b>HERMANN, MO</b>			23c. DATE SIGNED <b>12-2-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>12-4-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Loutrc Island Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>McKITTRICK Mo</b>			
DATE REC'D BY LOCAL REG. <b>12/3/55</b>		REGISTRAR'S SIGNATURE <b>79-0</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>HERMANN Mo</b>				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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.....  
Licensed Embalmer No. 316  
P. O. Address Hermann

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.