

FILED JAN 18 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43255

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>386</u>	
1. PLACE OF DEATH a. COUNTY <u>ADAIR</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>MO</u> b. COUNTY <u>PUTNAM</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>KIRKSVILLE</u>		c. LENGTH OF STAY (If in place) <u>1 Wk.</u>		c. CITY OR TOWN <u>WORTHINGTON</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 HOSPITAL OR INSTITUTION <u>R O Hosp. Ad.</u>				STREET ADDRESS (If rural, give location) <u>0869</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>CHARLES</u> (Middle) <u>Stelow</u> (Last) <u>Schwartz</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 28-55</u>				
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>		8. DATE OF BIRTH <u>APR 5-1894</u>		9. AGE (In years last birthday) <u>61</u> IF UNDER 1 YEAR Months <u>7</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work including those of working life, even if retired) <u>Refrigerator Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>AUGUSTAV Schwartz</u>			13b. MOTHER'S MAIDEN NAME <u>ELIZABETH HAYNES</u>		14. NAME OF HUSBAND OR WIFE <u>MARY Schwartz</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>unk</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS: <u>MARY Schwartz Worthington 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Embolism or Myocarditis.</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Uremia due to Chronic Glomerulonephritis.</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Chronic Glomerulonephritis.</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) <u>332x</u>			
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>12-19</u> , 19 <u>55</u> , to <u>12-28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-28</u> , 19 <u>55</u> , and that death occurred at <u>4:15 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>David W. Boone MD</u>				23b. ADDRESS <u>Nuttsville MO</u>		23c. DATE SIGNED <u>1-6-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24b. DATE <u>Dec 31, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek Home Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Putnam Co Mo</u>	
DATE REC'D BY LOCAL REG. <u>1-12-56</u>		REGISTRAR'S SIGNATURE <u>Kate Sambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. H. Husted Van Muncie Mo</u>			

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

9561 T N79

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 *Murl O. Husted*

Licensed Embalmer No. *30*

P. O. Address *Unknown*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.