

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20610

STATE FILE NUMBER

FILED JUL 12 1957

Registration District No. 114 Primary Registration District No. 4186 Registrar's No. 31

Health,  
Welfare  
Public  
Service

0361  
300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>SULLIVAN</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SULLIVAN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NORTHSIDE HOSP</u> Length of stay in 1b <u>2 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>OLSON HOME</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALVINA</u> Middle <u>L.</u> Last <u>SCHMIDT</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>3</u> Year <u>1957</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 22, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR Month <u>8</u> Day <u>11</u> IF UNDER 24 HRS. Hours <u>11</u> Min. _____
11. BIRTHPLACE (City and state or country) <u>MARTHASVILLE, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ERNEST BRUESEKE</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE SCHEER</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>NONE</u>	17. INFORMANT Address <u>WILLIAM SCHMIDT SULLIVAN, MO</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Arteriosclerotic Cardio Vascula Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 "</u> <u>Years</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION _____	COUNTY _____	STATE _____
21. I attended the deceased from <u>June 28-57</u> to <u>July 3-57</u> and last saw her <u>alive</u> on <u>July 3-57</u> Death occurred at <u>7:30 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert E. Crawford M.D.</u>		22b. ADDRESS <u>Sullivan, Mo.</u>	22c. DATE SIGNED <u>July 7-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JULY, 7, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S E.P.R. CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>SPRING BLUFF, MO</u>
24. FUNERAL DIRECTOR <u>H. Meator</u> ADDRESS <u>Sullivan, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-12-57</u>	26. REGISTRAR'S SIGNATURE <u>Charles A. Bridges</u>	

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 *J. G. Humphrey* .....

Licensed Embalmer No. *477*

P. O. Address *Sullivan*

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