

Health, Welfare
Public Service

FILED SEP 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28625
STATE FILE NUMBER

Registration District No. 171 Primary Registration District No. 5637 Registrar's No. 29

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| 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, give TOWNSHIP only) OR TOWN <u>Clay Twns.</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>Clay Twns</u> Inside Limits <u>05465</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6 Mi. North of Odessa-12 Yrs.</u> | | Length of stay in lb. | d. STREET ADDRESS (If outside, give location) <u>6 Mi. North of Odessa</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>David</u> Last <u>Schumaker</u> | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1957</u> | | |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr. 5, 1899</u> | 9. AGE (In years at birthday) <u>58</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Benton Co., Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U</u> |
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| 13a. FATHER'S NAME <u>Claus Schumaker</u> | 13b. MOTHER'S MAIDEN NAME <u>Arey Rogers</u> | 14. NAME OF HUSBAND OR WIFE <u>Elsie Schumaker</u> |
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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) <u>No.</u> | 16. SOCIAL SECURITY NO. <u>497-40-0573</u> | 17. INFORMANT Address <u>Mrs. Elsie Schumaker, Wellington</u> |
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| 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>Carcinoma of Both Lungs</u> | | INTENTED BETWEEN ONSET AND DEATH <u>8 mo.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>163x</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____ |
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| 21. I attended the deceased from <u>10-31-54</u> to <u>9-4-57</u> and last saw her/him alive on <u>9-4-57</u> . Death occurred at <u>4:45 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <u>Ed Embury DO.</u> (Degree or title) | 22b. ADDRESS <u>Wellington, Mo.</u> | 22c. DATE SIGNED <u>9-6-57</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Sept. 7, 1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenton Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Odessa, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Husman-Sparke</u> <u>Wm. F. Husman</u> | ADDRESS <u>Odessa Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>Sept. 6, 1957</u> | 26. REGISTRAR'S SIGNATURE <u>Emma Davidson</u> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Joseph L. Husman*

Licensed Embalmer No. *7541*

P. O. Address *Odessa, 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.