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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30628  
STATE FILE NUMBER

FILED AUG 20 1957

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 135

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LAWRENCE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>MOUNT VERNON, MO</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>State Hospital No 3</u>		Length of stay in lb <u>1 1/2 hrs 18 1/2</u>	d. STREET ADDRESS (If outside, give location) <u>AT "THE EDGES" 3 miles north of city</u>

3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>ERNEST</u> Last <u>SCHMIDT</u>			4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1957</u>		
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5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</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>December 1, 1876</u>	9. AGE (In years last birthday) <u>80</u>	IF FUNDER 1 YEAR Months <u>8</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>agriculture</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>HARDIN COUNTY, IOWA</u> <u>STEAMBOAT ROCK</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Karl W. Schmidt</u>	13b. MOTHER'S MAIDEN NAME <u>Flora Rust</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</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>None</u>	17. INFORMANT <u>Hospital records</u>	Address
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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>circulatory collapse</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Two days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Pneumonia Bronchial</u>	
	DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis 491X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 <u></u> Month <u></u> Day <u></u> Year <u></u> a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>March 1, 1956</u> to <u>Aug 13, 1957</u> and last saw her/him alive on <u>August 13, 1957</u> Death occurred at <u>12:35 A.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>W. C. Bradley M.D.</u> (Degree or title)	22b. ADDRESS <u>State Hospital #3, Nevada, Mo</u>	22c. DATE SIGNED <u>8-13-1957</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug-15-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hot Cemetery</u>	23d. LOCATION (City, town, or county) (Specify) <u>Mt. Vernon - Missouri</u>
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24. FUNERAL DIRECTOR <u>A. D. Fossett - Mt. Vernon, Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-13-1957</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Furvy</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 me; Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed H R Fossett

Licensed Embalmer No. 220  
P. O. Address mt Vernon

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.