

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014825  
STATE FILE NUMBER

FILED APR 22 1958

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 38

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0542  
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1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lexington</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Higginsville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Memorial Hospital</b>		Length of stay in lb <b>5 hrs.</b>	d. STREET ADDRESS (If outside, give location) <b>2 blocks E Hwy 13</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Albert</b> Last <b>Schowengerdt</b>			4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1958</b>		
5. SEX <b>male</b> <b>0</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1900</b>	9. AGE (In years last birthday) <b>58</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>27</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Loader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ice Plant</b>		11. BIRTHPLACE (City and state or country) <b>Higginsville, MO</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Louis H. Schowengerdt</b>		13b. MOTHER'S MAIDEN NAME <b>Lizzie Meld</b>	
13c. NAME OF HUSBAND OR WIFE <b>Mrs. Viola Schowengerdt</b>		14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>not</b>		16. SOCIAL SECURITY NO. <b>494-30-4200</b>	
15. 17. INFORMANT <b>Mrs. Viola Schowengerdt</b>		Address <b>Higginsville, MO</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>A.S.I.D.</b> DUE TO (c) <b>4200</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Delemon Tremors</b>	
INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs. several yrs.</b>		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.)		20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <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 <b>Higginsville</b>		COUNTY _____ STATE _____	
21. I attended the deceased from <b>1954</b> to <b>4-9-58</b> and last saw him alive on <b>4-9-58</b> Death occurred at <b>4:30 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Wilbur E. Fulmer M.D.</b>		22b. ADDRESS <b>Higginsville</b>	
22c. DATE SIGNED <b>4-12-58</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 11, 1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>city</b>		23d. LOCATION (City, town, or county) <b>Higginsville, MO.</b>		(State)	
24. FUNERAL DIRECTOR <b>F. A. Hofer</b>		ADDRESS <b>Higginsville, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>4-18-58</b>	
26. REGISTRAR'S SIGNATURE <b>Wm. J. Gustafson</b>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

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### 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 *Forest R. Hofer* .....

Licensed Embalmer No...4801.....  
P. O. Address Higginsville, MO.

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.