

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019009

STATE FILE NUMBER

FILED JUN 12 1958

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 188

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Marion</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Ralls,</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal, Mo.</b>                   |  | c. CITY OR TOWN <b>Center, Mo. R.F.D.</b>   |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Elizabeth Hospital</b> |  | d. STREET ADDRESS (If outside, give location) <b>Center Township</b>  |  |
| Length of stay in hospital <b>1wk</b>  |  | Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |

|  |                                  |   |  |  |   |  |
|--|----------------------------------|---|--|--|---|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>ADAM</b> Middle <b>SCHAFFER.</b> Last <b>SCHAFFER.</b>                 |                                  |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>7,</b> Year <b>1958</b> |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug 30, 1873</b>                              | 9. AGE (In years last birthday)<br><b>84</b> | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</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)<br><b>Farmer</b>           |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Palmyra, Mo.</b>    |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                 |  |
| 13. FATHER'S NAME<br><b>Marion Schaffer.</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown.</b>                          |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT Address<br><b>Marion Schaffer, Center, Mo.</b>         |  |   |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal bronchial pneumonia</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Cardio-vascular renal heart disease</b>                  |  | <b>unknown</b>                                    |
| DUE TO (c) _____   |  | <b>442X</b>                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                    |  |   |

|   |  |   |
|---|--|---|
| 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<br>Hour, Month, Day, Year<br>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 |

21. I attended the deceased from **6/2/58** to **6/7/58** and last saw <sup>him</sup> alive on **6/7/58**  
Death occurred at **5:00 P.** m on the date stated above; and to the best of my knowledge, from the causes stated.

|   |  |                                   |
|---|--|-----------------------------------|
| 22a. SIGNATURE<br><i>B. J. Murphy</i><br>B. J. Murphy, M.D. | 22b. ADDRESS<br><b>Hannibal, Missouri.</b> | 22c. DATE SIGNED<br><b>6-9-58</b> |
|---|--|-----------------------------------|

|  |                              |   |   |
|--|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>6-9-1958</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Olivet Cemetery,</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Center, Mo.</b> |
|--|------------------------------|---|---|

|  |                              |  |  |
|--|------------------------------|--|--|
| 24. FUNERAL DIRECTOR<br><i>Clyde Perry</i><br>Clyde Perry, Mo. | ADDRESS<br><b>Perry, Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>6-10-1958</b> | 26. REGISTRAR'S SIGNATURE<br><i>Dr. E. M. Luck</i> |
|--|------------------------------|--|--|

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

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

MEDICAL CERTIFICATION

1880

RECEIVED JUN 1 1 1958  
MARION CO. HEALTH DEPT  
DATE FILED JUN 1 1 1958

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.....  
*Alfred C. Wilkey*

Licensed Embalmer No..... 382

P. O. Address..... Perry, 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.