

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024465
STATE FILE NUMBER

FILED JUL 28 1958 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 237

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1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lynn	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkville		c. CITY OR TOWN New Boston R.F.D. 1	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Grim-Smith Hospital		d. STREET ADDRESS (If outside, give location) About 1/2 mile	
3. NAME OF DECEASED (Type or print) First Middle Last Stevin David Schoonover		4. DATE OF DEATH Month Day Year July 17 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21 1955
9. AGE (In years last birthday) 3		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (City and state or country) Unionville Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Billie L. Schoonover		13b. MOTHER'S MAIDEN NAME Ruth Dorthy Eckman	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Billie L. Schoonover Address New Boston, Mo. R.F.D. 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation			INTERVAL BETWEEN ONSET AND DEATH Instant
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Drowning			11
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m. 058			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION 058		COUNTY STATE	
21. I attended the deceased from July 17, 1958 to July 17, 1958 and last saw him alive on July 17, 1958 Death occurred at 5:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Milton T. Sughie, M.D.		22b. ADDRESS 1 Kirkville, Mo.	
22c. DATE SIGNED 7-19-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/20/58	
23c. NAME OF CEMETERY OR CREMATORY Lemons Cemetery		23d. LOCATION (City, town, or county) (State) lemons, Missouri	
24. FUNERAL DIRECTOR Comstock Funeral Home By S. W. Comstock		25. DATE RECD. BY LOCAL REG. 7-19-1958	
26. REGISTRAR'S SIGNATURE Doris W. Rathoff			

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *James W. Somsted*

Licensed Embalmer No. *4127*

P. O. Address *Unionville*

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. *