

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035243

STATE FILE NUMBER

FILED OCT 8 1958 Registration District No. 352 Primary Registration District No. 4516 Registrar's No. 88

1. PLACE OF DEATH a. COUNTY <b>Taney</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Taney</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Forsyth</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Forsyth</b>		1060 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>home Forsyth</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>Forsyth</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>RAYMOND GEORGE SCHMIDT</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>1</b> Year <b>1958</b>		
5. SEX <b>male</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>July 31, 1893</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mgr</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>machinery</b>	11. BIRTHPLACE (City and state or country) <b>Chicago Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>George Schmidt</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Ruth Schmidt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT Address <b>Mrs Ruth Schmidt Forsyth</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>Descending Aneurysm of abdominal aorta.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>7 da</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension.</b>					<b>6 mo</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) <b>451X</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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
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	COUNTY STATE
21. I attended the deceased from <b>Sept. 1<sup>st</sup> 58</b> to <b>Oct. 1 - 58</b> and last saw her/him alive on <b>Oct. 1<sup>st</sup> 58</b> Death occurred at <b>2 a.m.</b> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Hartley J. Mara</b>			22b. ADDRESS <b>Forsyth Mo</b>		22c. DATE SIGNED <b>Oct. 1. 58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-1-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Chicago Ill</b>	
24. FUNERAL DIRECTOR <b>W. J. Cobb</b>		ADDRESS <b>Forsyth Mo</b>	25. DATE RECD. BY LOCAL REG. <b>10-4-58</b>	26. REGISTRAR'S SIGNATURE <b>Helen Campbell</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secretary, coroner, or physician may stamp "no nonreportable" in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

OCT 9 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 *Walter S. Cobb* .....

Licensed Embalmer No. *4731* .....

P. O. Address *Longth 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.