

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039367

STATE FILE NUMBER

FILED DEC 15 1958 Registration District No. 86 Primary Registration District No. 5329 Registrar's No. 19-1958

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cuba, Cahill, Townsh.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Cuba</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>P. R. #1 (At Home)</u>			Length of stay in lb <u>30 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>R. R. # 1</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Malissa</u> Last <u>Schwidde</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>1958</u>		
5A. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 7, 1894</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Crawford Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>Andrew Jackson Pinell</u>		13b. MOTHER'S MAIDEN NAME <u>MARY MALISSA CONNEY</u>		14. NAME OF HUSBAND OR WIFE <u>John Henry Schwidde</u>	
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>John Henry Schwidde, Mal, Cuba, Mo.</u>		
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>Congestive Heart Failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>					<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>old cerebral accident</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.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ 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 <u>Dec. 1957</u> to <u>12 Dec 58</u> and last saw ^{her} _{him} alive on <u>9 Dec. 58</u> Death occurred at <u>6:10 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Ronald Van Audell, M.D.</u>			22b. ADDRESS <u>Bourbon, Mo.</u>		22c. DATE SIGNED <u>12 Dec 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 14, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cahill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cahill, Mo.</u>	
24. FUNERAL DIRECTOR <u>Paul Q. Shanthor</u>		ADDRESS <u>Cuba, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 13, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Paul Q. Shanthor</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

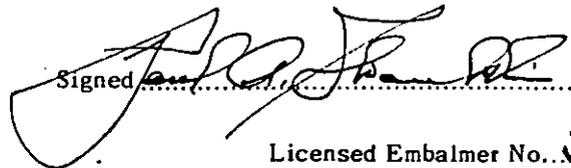
doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

DEC 15 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 

Licensed Embalmer No. 3479

P. O. Address Cuba, Md.

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.