

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044815

STATE FILE NUMBER

FILED JAN 8 1959 Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY LINN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY LINN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARCELINE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN MARCELINE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BUNTON REST HOME Length of stay in 1b		d. STREET ADDRESS (If outside, give location) N. KANSAS AVE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last ANNA WINIFRED SCHEAFER			4. DATE OF DEATH Month Day Year 12-20-1958		
5. SEX FEMALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 16 1875	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months 1 Days 7

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) Chicago Illinois	12. CITIZEN OF WHAT COUNTRY? USA
--	--	--	-------------------------------------

13. FATHER'S NAME Patrick William Kelly	14. MOTHER'S MAIDEN NAME Catherine Kelly
--	---

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. NO	17. INFORMANT Address Philip W. Scheafer
--	-------------------------------	---

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cardiac Decompensation	
	DUE TO (c) Arteriosclerotic Cardiovascular Disease	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) 4221		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 0
---	--	--

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 July 958 to Dec 1958 and last saw her alive on 12-20-58
Death occurred at 11:00 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George J. Taylor	22b. ADDRESS Marceline Missouri	22c. DATE SIGNED 12-22-58
--	------------------------------------	------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12-22-58	23c. NAME OF CEMETERY OR CREMATORY Mt. Killiard	23d. LOCATION (City, town, or county) (State) MARCELINE MO.
---	-----------------------	--	--

24. FUNERAL DIRECTOR ADDRESS Miller-Tillotson MARCELINE	25. DATE RECD. BY LOCAL REG. 12-23-58	26. REGISTRAR'S SIGNATURE Brookie Ockman
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

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

300
1-56

JAN 9 1959

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 *Lilliana K. Tillate*

Licensed Embalmer No. *45*

P. O. Address *Mass 140*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.