

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006100

STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 79

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arkansas</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Joplin</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rogers</u> 8150 8
c. FULL NAME OF (If NOT in hospital, give location) <u>St. John's</u>		Length of stay in, lb <u>20 min</u>	d. STREET ADDRESS (If outside, give location) <u>Rt #1</u>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD Clark Schnader</u>			4. DATE OF DEATH Month . Day Year <u>1-24-1959</u>	
5. SEX <u>Male</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>4-24-1936</u>	
9. AGE (In years last birthday) <u>22</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COOKING</u>	11. BIRTHPLACE (City and state or country) <u>Monterey, Calif.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				

13a. FATHER'S NAME <u>Edward Schnader</u>		13b. MOTHER'S MAIDEN NAME <u>Effie Hodge</u>		14. NAME OF HUSBAND OR WIFE <u>Dorothy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>EDWARD Schnader Rt #1, Rogers ARK</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>Extra and subdural hemorrhage, result of automobile accident.</u>			INTERVAL BETWEEN DEATH AND DEATH <u>Several hours.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Do not know. Patient dying when first seen by me.</u>					
DUE TO (c) <u>seen by me.</u>					
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"/> <u>2</u>

20a. ACCIDENT SUICIDE HOMICIDE <input checked="" 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.) <u>Received injuries in automobile accident near Neosho, Missouri early 1-24-59. Patient first taken to Sale Memorial Hospital in Neosho, Mo.</u>			
20c. TIME OF INJURY Hour X a.m. Month, Day, Year p.m. <u>1-24-59</u>					

20d. INJURY OCCURRED WHILE AT WORK <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.) <u>Public Highway</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>(Near Neosho) Newton Mo.</u>	
21. I attended the deceased from <u>1-24-59</u> to <u>1-24-59</u> and last saw ^{her} alive on <u>1-24-59</u> Death occurred at <u>1:00</u> a. m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE <u>Bill Taylor</u> (Typed or title)		22b. ADDRESS <u>410 Jackson, Joplin, Mo.</u>		22c. DATE SIGNED <u>2-10-59</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>1-24-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROGERS</u>		23d. LOCATION (City, town, or county) (State) <u>Rogers ARKANSAS</u>	
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24. FUNERAL DIRECTOR <u>Thorwhill-Dillon</u> ADDRESS <u>Joplin, MO</u>		25. DATE RECD. BY LOCAL REG. <u>2-12-59</u>		26. REGISTRAR'S SIGNATURE <u>Dove Merriam</u>	
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All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. MEDICAL CERTIFICATION

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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 *Robert C. Toller*

Licensed Embalmer No. *5062*

P. O. Address *Fogelin, 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.