

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED MAR 30 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 294

300
-57

1. PLACE OF DEATH a. COUNTY Euchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Euchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph <i>0110</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp.		d. STREET ADDRESS (If outside, give location) Route #1	
Length of stay in 1b 21 yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Anna Middle Lee Last Schubert			4. DATE OF DEATH Month March Day 18 Year 1959			
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1920	9. AGE (In years last birthday) 38	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator	10b. KIND OF BUSINESS OR INDUSTRY Western Tablet Co.	11. BIRTHPLACE (City and state or country) Rockport, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Frank Caudle	13b. MOTHER'S MAIDEN NAME Elizabeth Stacy	14. NAME OF HUSBAND OR WIFE Herman P. Schubert
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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. 488-14-0884	17. INFORMANT Herman P. Schubert, St. Joseph, Missouri	Address
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18. CAUSE OF DEATH (Enter only one cause but give for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomembranous enterocolitis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) antibiotic resistant bacteria	
	DUE TO (c) Acute Phlebotyphus & appendicitis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 585X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	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
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21. I attended the deceased from March 11, 1959 to March 18, 1959 and last saw her alive on March 18, 1959 Death occurred at 4:00 P. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) A. E. Slonson M.D.	22b. ADDRESS St. Joseph Mo	22c. DATE SIGNED 3-1959
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Mar. 21, 1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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24. FUNERAL DIRECTOR Wheeler-Henderson	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Mar. 20, 1959	26. REGISTRAR'S SIGNATURE Wm. Clark Goodell
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MEDICAL CERTIFICATION
ALL DISSEASES IN PART I MUST BE CAUSALLY RELATED.
DR. S. E. SLOAN ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Elbert B. Harrington*

Licensed Embalmer No.....

P. O. Address..... St. Joseph, 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.