

Dr. Fitch

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009100

STATE FILE NUMBER

LEO MAR 23 1959

Registration District No.

128

Primary Registration District No.

2000

Registrar's No.

268

300

1-57

1. PLACE OF DEATH a. COUNTY GREENE			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. MISSOURI b. COUNTY GREENE		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION MERCY HOSP.		Length of stay in lb 76 YRS.	d. STREET ADDRESS (If outside, give location) 1630 N. DOUGLES		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARIE Middle WOOD Last SCHALLER			4. DATE OF DEATH Month MARCH Day 11 Year 1959		
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 MAY 5 1870	9. AGE (In years as of birthday) 88	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) HOME		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) HARRISONBURG, W., VA		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME H.N.B. WOOD		13b. MOTHER'S MAIDEN NAME MARTHA WOOD		14. NAME OF HUSBAND OR WIFE FRANK SCHALLER (DEC.)	
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 MILDRED WOOD Address SPRINGFIELD, MO.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RENAL VASCULAR DISEASE					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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)					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. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Sept 1948 to MAR 11-1959 and last saw her alive on MARCH 7-1959 Death occurred at 7:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Max Kell</i> (Degree <i>MD.</i>)			22b. ADDRESS 1715 BOONVILLE SPRINGFIELD MO		22c. DATE SIGNED 3-13-59
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
BURIAL		3/14/59	GREENLAWN		SPRINGFIELD, MO.
24. FUNERAL DIRECTOR H.H. LOHMEYER ADDRESS SPRINGFIELD, MO.			25. DATE RECD. BY LOCAL REG. 3-16-59		26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Gene C. Hunt*

Licensed Embalmer No. *41439*

P. O. Address *St. Louis, 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.