

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010303

STATE FILE NUMBER

FILED APR 7 1959

Registration District No. 221

Primary Registration District No.

Registrar's No. 76

300  
1-57

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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.

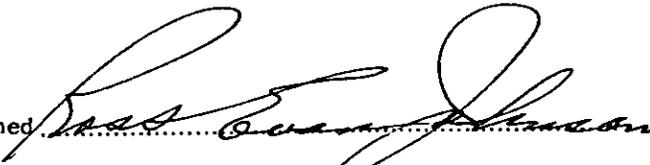
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>NO DAWAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <u>Mo</u> b. COUNTY <u>NO DAWAY</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLYDE, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Clyde</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BENEDICTINE CONVENT</u>		Length of stay in lb <u>71 yrs.</u>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SISTER MARY INNOCENT SCHRADER</u>				4. DATE OF DEATH Month Day Year <u>3 - 27 - 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHT</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-12-1871</u>		9. AGE (In years last birthday) <u>87</u>	F UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RELIGIOUS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CATHOLIC NON</u>		11. BIRTHPLACE (City and state or country) <u>MARYVILLE, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>PETER SCHRADER</u>			13b. MOTHER'S MAIDEN NAME <u>CELESTINE MAGETTE</u>			14. NAME OF HUSBAND OR WIFE	
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>Regina P. Convent - Clyde, Mo.</u>		Address	
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>Acute Pulmonary Hemorrhage</u> <u>Chc. Pulmonary Tuberculosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Chc. Pulmonary Tuberculosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>602X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>&gt; 10 yrs -</u>	
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. Month, Day, Year 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>3/19/59</u> to <u>3/27/59</u> and last saw her/him alive on <u>2/6/59</u> Death occurred at <u>1:20 AM</u> <u>1:20</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>Maryville, Mo</u>		22c. DATE SIGNED <u>3/31/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>3-30-59</u>	<u>St Calvary</u>		<u>Clyde, Mo.</u>		
24. FUNERAL DIRECTOR <u>Johnson Funeral Home</u> ADDRESS <u>[Address]</u>			25. DATE RECD. BY LOCAL REG. <u>3-31-59</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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. 7948

P. O. Address 

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.