No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012583
State File No.

FILED MAY 5 1959

BIRTH NO. REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 157

1. PLACE OF DEATH
a. COUNTY Cape Girardeau
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cape Girardeau
c. LENGTH OF STAY (In this place) 2 da.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Francis Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Scott
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jackson
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) THERESA
b. (Middle) ANN
c. (Last) SCHOEN

4. DATE OF DEATH (Month) (Day) (Year) APR 10, 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Jan 15, 1883
9. AGE (In years last birthday) 76 | 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Charleston, Mo
12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME GIBBEAR
13b. MOTHER'S MAIDEN NAME Don't Know
14. NAME OF HUSBAND OR WIFE Wm Schoen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Mrs Theon Schaefer
ADDRESS Jackson, Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 4.22.1
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8 Apr, 1959, *to* 10 Apr, 1959, *that I last saw the deceased alive on* 10 Apr, 1959 *and that death occurred at* 6:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Hugh V. Ashley Jr (Degree or title) MD
23b. ADDRESS Cape Girardeau Mo
23c. DATE SIGNED 4-12-59

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 4-13-59
24c. NAME OF CEMETERY OR CREMATORY St Augustine's
24d. LOCATION (City, town, or county) (State) Kelso, Missouri

DATE REC'D BY LOCAL REG. 4-30-59
REGISTRAR'S SIGNATURE Irene Koster
25. FUNERAL DIRECTOR'S SIGNATURE Bagling Goff Funeral Home
ADDRESS Illmo, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Item 7 added by funeral director 5-12-59

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 _____
Student Embalmer

Signed Oliver Clemmie

Licensed Embalmer No. 4470

P. O. Address Illmo, 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 this body is not embalmed, fact should be so stated above.