

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018745
STATE FILE NUMBER

FILED MAY 21 1959

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 58

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-57

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Minnesota</u> b. COUNTY <u>Carver</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Waynesville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Waconia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>		Length of stay in lb <u>6 wks</u>	d. STREET ADDRESS (If outside, give location) <u>441 E 1st St</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Kathy</u> Middle <u>None</u> Last <u>Schmakel</u>			4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Mar 23, 1959</u>
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Ft Leonard Wood, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Walter W Schmakel</u>		13b. MOTHER'S MAIDEN NAME <u>Delores M Luebke</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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>Walter W Schmakel</u> Address <u>Waynesville, Missouri</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>Suffocation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			<u>9240</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>18</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input checked="" 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.) <u>Infant was in car crib- evidentially was smothered</u>		
20c. TIME OF INJURY Hour <u>9</u> Month <u>5</u> Day <u>7</u> Year <u>59</u> P.M. <u>5</u>	by blanket <u>085</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>residence</u>	20f. CITY, TOWN, OR LOCATION <u>Waynesville</u>	COUNTY <u>Pulaski</u> STATE <u>Missouri</u>
21. I attended the deceased <u>at home</u> , to _____, and last saw her <u>at home</u> on <u>May 7 1959</u> Death occurred at <u>9</u> P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. Hedges</u>		(Degree or title) <u>3</u>	22b. ADDRESS <u>Richland, Missouri</u>
22c. DATE SIGNED <u>May 9 1959</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>May 9 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Waconia Minnesota</u>
24. FUNERAL DIRECTOR <u>HEDGES FUNERAL HOMES INC CROCKER</u>		25. DATE RECD. BY LOCAL REG. <u>MO 5-9-59</u>	26. REGISTRAR'S SIGNATURE <u>Anna Marie Anderson</u>

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 *Clarence Johnson*

Licensed Embalmer No. *4896*

P. O. Address *Waynsville, N.C.*

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.