

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020793

STATE FILE NUMBER

FILED JUN 29 1959 Registration District No. 82 Primary Registration District No. 5320 Registrar's No. 82

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cooper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Palestine Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Bunceton, Mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RFD Bunceton, Mo.		Length of stay in lb 30 yrs	d. STREET ADDRESS RFD (If outside, give location) 0270
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ERHARDT Last SCHIERHOLTZ			4. DATE OF DEATH Month June Day 19, Year 1959
5. SEX male	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 July 2, 1887
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		9b. KIND OF BUSINESS OR INDUSTRY agriculture	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Henry Schierholtz		13b. MOTHER'S MAIDEN NAME Mary Branch	14. NAME OF HUSBAND OR WIFE Jennie A. Schierholtz
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. unknown	17. INFORMANT Mrs Wm. Schierholtz Address RFD Bunceton,
18. CAUSE OF DEATH (Enter only one cause of line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic heart disease Arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH. 2 yrs.
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.) 4200	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		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	
21. I attended the deceased from April 1959 to June 1959 and last saw him alive on June 1-59 Death occurred at 2:45 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) H. DeGraeger M.D.		22b. ADDRESS Boonville Mo	
22c. DATE SIGNED 6/20/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE June 21/59	23c. NAME OF CEMETERY OR CREMATORY Walnut Grove Cem.	23d. LOCATION (City, town, or county) (State) Boonville, Mo.
24. FUNERAL DIRECTOR B. W. Thacher		ADDRESS Boonville, Mo.	25. DATE RECD. BY LOCAL REG. 6/21/59
			26. REGISTRAR'S SIGNATURE S. Hooper

(Licensed Embalmer's Statement on Reverse Side)

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

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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 *Berry W. Shaker* .....

Licensed Embalmer No. *3944* .....

P. O. Address *Boonville, 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.