

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020921

STATE FILE NUMBER

FILED JUN 16 1959

Registration District No.

119

Primary Registration District No.

5936

Registrar's No.

26

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>GASCONADE</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>GASCONADE</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>BOEUF TWP</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>HERMANN</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3 mi. S. of SWISS</b>		Length of stay in 1b <b>1 month</b>	d. STREET ADDRESS (If outside, give location) <b>037 1/2 124 E. 3rd ST</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>ELISA</b> Last <b>SCHIEDEGGER</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>3</b> Year <b>1959</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 29-1877</b>	9. AGE (In years last birthday) <b>82</b>	10. FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>CASE Mo 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>FREDRICK LESSINGER</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA SCHNEIDER</b>		14. NAME OF HUSBAND OR WIFE <b>Geo. Schiedegger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>HARRY Schiedegger</b> Address <b>R#1 HERMANN Mo</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> Interval between ONSET and DEATH <b>48 hrs.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Chronic myocarditis</b> Interval between ONSET and DEATH <b>Unknown</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) <b>Acute renal failure</b> <b>4222</b>					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 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 <b>6/2/59</b> to <b>6/3/59</b> and last saw her <sup>alive</sup> on <b>6/3/59</b> Death occurred at <b>10:45 A. M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>W. A. Jeter, M.D.</b> (Degree or title)			22b. ADDRESS <b>Hermann, Missouri</b>		22c. DATE SIGNED <b>6/5/59</b>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/7/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SWISS PRESBY. CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>RFD HERMANN Mo</b>
24. FUNERAL DIRECTOR <b>HUGO H BLUMER</b> ADDRESS <b>HERMANN Mo</b>		25. DATE RECD. BY LOCAL REG. <b>6-5-59</b>		26. REGISTRAR'S SIGNATURE <b>Delma Uffelmann</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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. 5055

P. O. Address *Demona, 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.