

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-022563

FILED JUL 13 1959

Registration District No. 306 Primary Registration District No. 6048 Registrar's No. 16

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St Charles</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN _____ Length of stay in 1b <u>83 yrs</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rural Rt Weldon Sprrs.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u> c. CITY OR TOWN <u>Weldon Springs</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Rural Rt 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>August</u> Last <u>Schlote</u>			4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/1875</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Hamburg Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>George Schlote</u>			13b. MOTHER'S MAIDEN NAME <u>Katherine Bates</u>		14. NAME OF HUSBAND OR WIFE <u>Gussie Schlote</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>494-42-5851</u>		17. INFORMANT Address <u>Mrs Gussie Schlote Weldon Sprrs Mo</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>Shock and Internal Injuries</u> DUE TO (b) <u>Being Drug by team of horses</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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>Fell off wagon - Reins wrapped around legs - Team ran off</u>					
20c. TIME OF INJURY Hour <u>10:30</u> a.m. _____ m. _____ Month, Day, Year <u>July 1, 1959</u>	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>on farm</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Weldon Springs St Charles Mo</u>					
21. I attended the deceased from <u>July 1, 1951</u> to <u>July 1, 1959</u> and last saw <u>her</u> alive on <u>July 1, 1959</u> Death occurred at <u>12:30 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Harold G. Mangoly D.O.</u>			22b. ADDRESS <u>O. Fallon Mo</u>		22c. DATE SIGNED <u>July 4 1959</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/4/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Weldon Springs</u>		23d. LOCATION (City, town, or county) (State) <u>Weldon Springs Mo</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Arthur C Baue St Charles Mo</u>			25. DATE RECD. BY LOCAL REG. <u>7-4-59</u>	24. REGISTRAR'S SIGNATURE <u>Earl [Signature]</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed David C. Bann

Licensed Embalmer No. 5060

P. O. Address St. Charles

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.