

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028016

FILED VS SEP 8 1959

Registration District No. _____ Primary Registration District No. 002 Registrar's No. 2019 48 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Andrew		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rochester		c. CITY OR TOWN St. Joseph	
Length of stay in 1b 6 wks.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Shady Lawn Rest Home		d. STREET ADDRESS (If outside, give location) R.R. #1	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Herman Middle G Last Schwader			4. DATE OF DEATH Month August Day 25 Year 1959		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1875	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed	10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (City and state or country) Wertenberg, Germany	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Gottfried Schwader	13b. MOTHER'S MAIDEN NAME Christina Rebecca Kinzer	14. NAME OF HUSBAND OR WIFE Laura Belle Schwader
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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 Lester Schwader, St. Joseph, Missouri
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arterial Disease		INTERVAL BETWEEN ONSET AND DEATH 5 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized Arteriosclerosis	10 yrs.
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senile psychosis	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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from 7-10-59 to 8-25-59 and last saw him alive on 8-24-59
Death occurred at 12:00 Noon m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Warren C. Baker M.D.	22b. ADDRESS Savannah, Mo.	22c. DATE SIGNED 8-27-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Aug. 27, 1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Joseph, Missouri
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24. FUNERAL DIRECTOR W. Schaeffer-Hessinger ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. 8-28-59	26. REGISTRAR'S SIGNATURE Lillian Sparks
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert C. Harr

Licensed Embalmer No. 325

P. O. Address St. Louis

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