

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 9 1959

59-029741

Registration District No. 195 Primary Registration District No. \_\_\_\_\_ Registrar's No. 71-59 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>McDonald</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>McDonald</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Anderson</u>		Length of stay in 1b <u>life</u>	c. CITY OR TOWN <u>Anderson</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RT 3</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RT. 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Otto</u> Last <u>Schlessman</u>			4. DATE OF DEATH Month <u>7</u> - Day <u>30</u> - Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>4-4-1912</u>	9. AGE (last birthday) <u>47</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>26</u>
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>Anderson Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>

13a. FATHER'S NAME <u>Grant Schlessman</u>	13b. MOTHER'S MAIDEN NAME <u>Mae Arhin</u>	14. NAME OF HUSBAND OR WIFE <u>Neva Schlessman</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>Mrs Neva Schlessman Anderson</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>Severed Aorta &amp; Rupt. Lung.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (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)	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 checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART II or PART III of item 18.) <u>Fall in Saw-Working at Saw Mill</u>
20c. TIME OF INJURY Hour <u>3:00</u> p.m. Month, Day, Year <u>7-30-59</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Farm</u>	20e. CITY, TOWN, OR LOCATION <u>Anderson, Mo</u>
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	COUNTY <u>McDonald</u> STATE	

21. I attended the deceased from 3:00 p.m. 7-30-59 to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at 3:00 p.m. 7-30-59 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. M. Humphrey Jr. Coroner</u>	22b. ADDRESS <u>Noel Mo.</u>	22c. DATE SIGNED <u>8-1-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-1-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tracy Cem</u>
23d. LOCATION (City, town, or county) <u>Anderson</u>		(State) <u>Mo. RT 3</u>

24. FUNERAL DIRECTOR <u>Humphrey &amp; Sons &amp; Hanna</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 4, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Thomas C. Dunder</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

**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 *W. M. Humphrey Jr.*

Licensed Embalmer No. 4708

P. O. Address Mad, Mo

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.