

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031927

FILED VS SEP 21 1959

STATE FILE NUMBER

Registration District No. 215-116 Primary Registration District No. 3020 Registrar's No. 200

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASHINGTON</u>		Length of stay in 1b <u>15 WKS.</u>		c. CITY OR TOWN <u>SULLIVAN</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>ST. FRANCIS HOSP</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R.R. I</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH BARBARA SCHAFFER</u>				4. DATE OF DEATH Month Day Year <u>SEPT. 15 1959</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 25 1874</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>20</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and state or country) <u>PORT HUDSON, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>JOHN STELZER</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH GROSS</u>		14. NAME OF HUSBAND OR WIFE <u>HENRY J. SCHAFFER</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 Address <u>ANNA SCHAFFER, SULLIVAN, 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>cerebral thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>General arteriosclerosis</u>							<u>1 yr</u>	
DUE TO (c) <u></u>							<u></u>	
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 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. <u></u>		Month, Day, Year <u></u>						
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.) <u></u>		20f. CITY, TOWN, OR LOCATION <u></u>		COUNTY STATE <u></u>		
21. I attended the deceased from <u>July 1948</u> to <u>9/15/59</u> and last saw her/him alive on <u>9/13/59</u> Death occurred at <u>11:15 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>John J. Detamore</u> (Degree or title)				22b. ADDRESS <u>Sullivan, Mo</u>		22c. DATE SIGNED <u>9/17/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>SEPT. 18, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOLY MARTYRS OF JAPAN</u>		23d. LOCATION (City, town, or county) <u>SULLIVAN R.R. I MO.</u>		(State)	
24. FUNERAL DIRECTOR <u>H.M. EATON</u>		ADDRESS <u>SULLIVAN, MO</u>		25. DATE RECD. BY LOCAL REG. <u>9/18/59</u>		26. REGISTRAR'S SIGNATURE <u>J.P. Schumann</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. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harrison N. Eaton

Licensed Embalmer No. 5066

P. O. Address Sullivan, Pa

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.