

CERTIFICATE OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 9 1959

59-035451
STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 392

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

3. NAME OF DECEASED (Type or print) First: <u>Allen</u> Middle: <u>Wayne</u> Last: <u>Schearf</u>			4. DATE OF DEATH Month: <u>Oct</u> Day: <u>25</u> Year: <u>1959</u>	
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 23 1959</u>	9. AGE (last birthday) <u>2</u> Months <u>2</u> Days IF UNDER 1 YEAR 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) <u>no</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>no</u>	11. BIRTHPLACE (City and state or country) <u>Cape Girardeau U.S.A</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>Alvin Schearf</u>	13b. MOTHER'S MAIDEN NAME <u>Maebell Bradshaw</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Mr Alvin Schearf</u> Address <u>Delta Mo.</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>
IMMEDIATE CAUSE (a)	<u>congolocoeal</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Vertical defect, abdominal wall</u>	
	DUE TO (c) <u>Congenital</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
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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 <u>6:00</u> Month, Day, Year <u>10-23-59</u> 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 <u>Cape Girardeau Mo</u>	COUNTY <u>Delta Mo.</u>	STATE
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21. I attended the deceased from <u>10-23-59</u> to <u>10-25-59</u> and last saw him alive on <u>11 PM 10-21-59</u> Death occurred at <u>6:00 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Dr R Cochran MD</u> (Degree or title)	22b. ADDRESS <u>Cape Girardeau Mo</u>	22c. DATE SIGNED <u>11-3-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 26 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kenyon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Delta Mo.</u>
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24. FUNERAL DIRECTOR <u>Brinkopf Howell</u> ADDRESS <u>Cape Gir Mo.</u>	25. DATE RECD BY LOCAL REG. <u>11-5-1959</u>	26. REGISTRAR'S SIGNATURE <u>Irvin Kasten</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Neil H. Grossheider

Licensed Embalmer No. 4994

P. O. Address Cape Girardeau

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.