

FEDERAL BUREAU OF INVESTIGATION
URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036806

FILED VS OCT 26 1959

STATE FILE NUMBER

Registration District No. 279 Primary Registration District No. 5667 Registrar's No. 88

RENDERED

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bedford</u> Length of stay in 1b <u>16da</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lincoln County Memorial Hospital</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>Lincoln</u> c. CITY OR TOWN <u>Troy</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>443 Boone St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NANCY CORDELIA SCHAPER</u>			4. DATE OF DEATH Month Day Year <u>October 22, 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>Nov. 8, 1879</u>	9. AGE (last birthday) <u>79</u> IF UNDER 1 YEAR IF UNDER 24 HR Months <u>11</u> Days <u>14</u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Troy MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Chas Harrell</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Bayles</u>		14. NAME OF HUSBAND OR WIFE <u>Louis Schaper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Garfield Schaper Troy 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 Apoplexy.</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>46 hours</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Fracture of left Hip.</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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>Patient fell at home. 10/6/59.</u>					
20c. TIME OF INJURY Hour Month, Day, Year <u>4:30 p.m. 10-6-59</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Troy MO.</u>	20g. COUNTY <u>Lincoln</u>		
21. I attended the deceased from <u>10/6/59</u> to <u>Oct 22, 1959</u> and last saw her alive on <u>10/22/59</u> . Death occurred at <u>10:22/59</u> <u>10:00 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
21a. SIGNATURE (Name or title) <u>Charles E. Leek M.D.</u>			21b. ADDRESS <u>Troy MO</u>		21c. DATE SIGNED <u>10/23/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 22, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Troy Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Troy MO.</u>				
24. FUNERAL DIRECTOR <u>D.W. McCoy</u> <u>Troy MO.</u>		25. DATE RECD. BY LOCAL REG. <u>10-23-59</u>	26. REGISTRAR'S SIGNATURE <u>Charlotte Leek</u>				

(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 D. D. McBay

Licensed Embalmer No. 35-86

P. O. Address Troy Mo.

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.