

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-036942**

FILED VS **OCT 26 1959**  
 SCHEDULED

STATE FILE NUMBER

Registration District No. **224** Primary Registration District No. **5793** Registrar's No. **91**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Moniteau</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Moniteau</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Linn Township</b>		Length of stay in 1b <b>82 yrs.</b>		c. CITY OR TOWN <b>Jamestown, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4 mi. N. Jamestown, Mo.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4 Mi. N. Jamestown</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>William</b> Middle <b>(none)</b> Last <b>SCHUSTER</b>				<b>4. DATE OF DEATH</b> Month <b>10</b> Day <b>22</b> Year <b>1959</b>									
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10-20-1877</b>		<b>9. AGE (last birthday)</b> <b>82</b>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HR.</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Moniteau Co., Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>United States</b>					
<b>13a. FATHER'S NAME</b> <b>John William SCHUSTER</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Elizabeth SCHMUTZ</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Alice DEARING</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)   (If yes, give war or dates of service) <b>No.</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Sophia MILLER, Jamestown, Mo.</b>				Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO (b) <b>Acute Myocardial Failure</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Senility</b>								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					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____				<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>	
<b>21. I attended the deceased from <u>On 10-22-59 only</u> and last saw him alive on <u>11</u> deceased when seen. coroner notified, undersigned advised to complete certifi-                  Death occurred at <u>Moniteau</u> on the date stated above, and to the best of my knowledge, from the causes stated.                  I certify that death occurred about <u>5:30 p.m.</u> </b>													
<b>22a. SIGNATURE</b> (Degree or title) <i>[Signature]</i> <b>D. O.</b>						<b>22b. ADDRESS</b> <b>Jamestown, Missouri</b>			<b>22c. DATE SIGNED</b> <b>10-22-59</b>				
<b>23a. BURIAL, CREMATION, OR REMOVAL (Specify)</b> <b>Burial</b>			<b>23b. DATE</b> <b>10-24-59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Moniteau Cemetery near Jamestown Mo</b>			<b>23d. LOCATION</b> (City, town, or county) (State)					
<b>24. FUNERAL DIRECTOR</b> <i>[Signature]</i>					<b>25. DATE RECD. BY LOCAL REG.</b> <b>10/24/59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>						

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 G. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Basie Home 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.