

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041416

FILED VS. NOV 24 1959 310

Primary Registration District No. 3058 Registrar's No. 269

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u> Length of stay in lb <u>33 Yrs.</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Charles</u> c. CITY OR TOWN <u>St. Charles</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2102 N. Fourth St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anton</u> Middle <u>T.</u> Last <u>Schroff</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>12,</u> Year <u>1959</u>				
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 checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27, 1883</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>15</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>Store Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Business</u>		11. BIRTHPLACE (City and state or country) <u>Marceline, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles Schroff</u>			13b. MOTHER'S MAIDEN NAME <u>Nellie Dyckman</u>		14. NAME OF HUSBAND OR WIFE <u>Lydia Bauer</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>498-16-8479</u>		17. INFORMANT Address <u>Ill.</u> <u>Mrs. Emma McKinney, Woodriver,</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>Bronchopneumonia, acute</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <u>Chronic Pulmonary Fibrosis</u>					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 checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. Month, Day, Year _____		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 COUNTY STATE	
21. I attended the deceased from <u>1-11-57</u> to <u>11-12-59</u> and last saw him alive on <u>11-12-59</u> Death occurred at <u>12:50</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Paul H. Rother MD</u>				22b. ADDRESS <u>St. Charles, Mo</u>		22c. DATE SIGNED <u>11-13-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov 15, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Big Springs, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Mo.</u> <u>H.C. Dallmeyer & Sons, St. Charles,</u>			25. DATE RECD. BY LOCAL REG. <u>Nov. 14-59</u>		26. REGISTRAR'S SIGNATURE <u>Murella Wilson</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 me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Frank Amalongo

Licensed Embalmer No. 483

P. O. Address St. Charles

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.