

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000074

FILED VS JAN 22 1960

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3002

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STATE FILE NUMBER

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

DED

2-5-60
 Catherine Schroit
 Catherine Schierholtz
 Catherine Schierholtz
 BY AFFIDAVIT OF Informant

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		Length of stay in 1b <u>5 days</u>		c. CITY OR TOWN <u>Wellsville</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>Allen Nurseing Home</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RR #2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>H. SCHWENEKER</u> Last <u>SCHWENKER</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>10</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 9, 1883</u>		9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>1</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>retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General farming</u>		11. BIRTHPLACE (City and state or country) <u>Montgomery Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>					
13a. FATHER'S NAME <u>SCHWENKER</u> <u>Christian Schweneker</u>				13b. MOTHER'S MAIDEN NAME <u>SCHIERHOLTZ</u> <u>Catherine Schierholtz</u>				14. NAME OF HUSBAND OR WIFE <u>Mrs. Elizabeth Wicklein</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>Mrs. Elizabeth Wicklein, Wellsville</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>Cardiac failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>General infarction of eye</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>5 yrs</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 <u></u> a.m. <u></u> 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>Jan 10, 1960</u> to <u>Jan 10, 1960</u> and last saw him alive on <u>Jan 10, 1960</u> Death occurred at <u>6 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>M. Kallbach M.D.</u>						22b. ADDRESS <u>Mexico, Mo</u>				22c. DATE SIGNED <u>Jan 13, 1960</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/12/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wellsville City</u>				23d. LOCATION (City, town, or county) (Site) <u>Wellsville, Missouri</u>					
24. FUNERAL DIRECTOR <u>R. B. Wells</u> ADDRESS <u>Wellsville, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>JAN-12-1960</u>				26. REGISTRAR'S SIGNATURE <u>Blanche Reely</u>					

STATEMENT BY LICENSED EMBALMER

FEB

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Howard F. Myers

Licensed Embalmer No. 4494

P. O. Address Wellsville, N.Y.

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.