

RI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000484

FILED VS. FEB 15 1960

43

REG. NO. A-2060

3007

Registrar's No. 75

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>NEW MADRID</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Length of stay in 1b <b>1 DAY</b>		c. CITY OR TOWN <b>LILBOURN</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADM. HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>NONE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>LESTER</b> Last <b>SCHAFFER</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>30</b> Year <b>1960</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/22/1911</b>	9. AGE (last birthday) <b>CS 65</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>8</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (City and state or country) <b>ELIZABETHTOWN, ILL.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>JOHN SCHAFFER</b>			13b. MOTHER'S MAIDEN NAME <b>IDA BELL CRIDER</b>			14. NAME OF HUSBAND OR WIFE <b>ETTIE SCHAFFER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>			16. SOCIAL SECURITY NO. <b>489148202</b>		17. INFORMANT Address <b>MRS. ETTIE SCHAFFER, LILBOURN, MO. (WIFE)</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 HOURS.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>HYPERTENSION.</b>							SEV. YEARS		
DUE TO (c) <b>ARTERIOSCLEROSIS.</b>							SEV. YEARS		
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 <b></b> a.m. <b></b> p.m. <b></b>		Month, Day, Year <b></b>		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 <b>9:50PM, 1/30/60</b> to <b>11:15PM, 1/30/60</b> and last saw her/him alive on <b></b>				Death occurred at <b>11:15 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Robert S. Cohen</i> <b>ROBERT S. COHEN, M.D., Chief, Medical Svc.</b>				22b. ADDRESS <b>BLUFF, MO. VETERANS ADM. HOSPITAL, POPLAR</b>				22c. DATE SIGNED <b>2/2/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-2-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mounds Park Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Near Lilbourn, Mo.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Ponder Funeral Home-Lilbourn, Mo.</b>				25. DATE RECD BY LOCAL REG. <b>2/5/60</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS FEB 15 1960

**STATEMENT BY LICENSED EMBALMER**

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

*Homer L. Ponder*

Licensed Embalmer No.

*3367*

P. O. Address

*Tilbourn*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.