

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000970

FILED VS. JAN 29 1960

Primary Registration District No. 5426 Registrar's No. 39

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boles Township</u>		Length of stay in lb <u>86 yrs.</u>		c. CITY OR TOWN <u>Pacific</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>3 1/2 mi n. of Pacific</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3 1/2 mi n. of Pacific</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Otto</u> Middle <u>J.</u> Last <u>Schuster</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>25</u> Year <u>1960.</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>wh.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 11, 1873</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </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>farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>Pacific Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>John J. Schuster</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Mary Becker</u>		14. NAME OF HUSBAND OR WIFE <u>Dora H. Schuster.</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 <u>Dora H. Schuster Pacific Mo</u>			Address
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 hemorrhage -</u> DUE TO (b) <u>Arteriosclerosis hypotensiva</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>1 1/2 hr</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 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
20f. STATE	21. I attended the deceased from <u>1-21-60</u> to <u>1-25-60</u> and last saw him alive on <u>1-25-60</u> Death occurred at <u>7:40 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>D. Weaver M.D.</u>				22b. ADDRESS <u>Pacific Mo.</u>		22c. DATE SIGNED <u>1-27-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>	23b. DATE <u>Jan 28 '60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Home</u>		23d. LOCATION (City, town, or county) <u>Pacific</u>		23e. STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Mrs. John L. Schick</u>			ADDRESS <u>  </u>	25. DATE RECD. BY LOCAL REG. <u>Jan. 28 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mary B. Gross.</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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ralph Oltmann

Licensed Embalmer No. 4808

P. O. Address Union, 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.