RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

60-010012
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 386

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Length of stay in 1b: Life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 2704 South 25th — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First LOUIS Middle A. Last SCHOENBORN
4. DATE OF DEATH Month March Day 26, Year 1960
5. SEX Male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 4-25-1885
9. AGE (last birthday) 74 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (14) Butcher
10b. KIND OF BUSINESS OR INDUSTRY Packing Co.
11. BIRTHPLACE (City and state or country) St. Joseph, Mo.
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Adam Schoenborn
13b. MOTHER'S MAIDEN NAME Barbara Not Known
14. NAME OF HUSBAND OR WIFE Barbara Schoenborn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 491-09-4312
17. INFORMANT Mrs R.F.Fowler Address Borger, Texas

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral thrombosis	5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cerebral arteriosclerosis	several years
DUE TO (c)		

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 May 19 54, to March 29, 1960 and last saw him/her alive on March 24
Death occurred at 11 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Lucile W. Ide (Degree or title) M.D.
22b. ADDRESS 902 Edmond St Joseph, Mo
22c. DATE SIGNED 3-29-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 3-29-60
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.

24. FUNERAL DIRECTOR H.O. Sidenfaden & Son ADDRESS St Joseph, Mo
25. DATE RECD. BY LOCAL REG. Mar. 29, 1960
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF L.W. Ide, M.D. — MEDICAL CERTIFICATION — DOCUMENT

Carbonier

JUN 1 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 _____ Signed Robert R Gaple

Signature of Student Embalmer

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo

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