

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010491

FILED VS APR 11 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 72 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>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>WASHINGTON</u>		Length of stay in 1b <u>11 WKS.</u>		c. CITY OR TOWN <u>SULLIVAN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS Hosp</u>				d. STREET ADDRESS (If outside, give location) <u>216 WATSON ROAD</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE ALBERT SCHMIDT</u>				4. DATE OF DEATH Month Day Year <u>APRIL 2 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</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>APRIL 21 1874</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		9. AGE (last birthday) <u>85</u>		11. BIRTHPLACE (City and state or country) <u>STRAIN, Mo.</u>	
13a. FATHER'S NAME <u>ADOLPH SCHMIDT</u>				13b. MOTHER'S MAIDEN NAME <u>DORA RAPPS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
14. NAME OF HUSBAND OR WIFE <u>MARY JUMP</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>MARY SCHMIDT SULLIVAN, Mo.</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>Cerebral Thrombosis</u> DUE TO (b) <u>General arteriosclerosis yrs.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Capillary Carcinoma of Bladder</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 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 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>1957</u> to <u>1960</u> and last saw ^{her} him alive on <u>April 1, 1960</u> Death occurred at <u>2:10 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>J. de la Torre MD</u>				22b. ADDRESS <u>Sullivan, Mo.</u>		22c. DATE SIGNED <u>4/3/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APRIL 4, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SCHMIDT CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SULLIVAN RRT MO.</u>	
24. FUNERAL DIRECTOR <u>H.M. EATON</u>		ADDRESS <u>SULLIVAN, Mo.</u>		25. DATE REGD. BY LOCAL REG. <u>4/4/60</u>		26. REGISTRAR'S SIGNATURE <u>J. de la Torre</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 Harrison W. Eator

Licensed Embalmer No. 50166

P. O. Address Sullivan

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.