

# VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014432

FILED VS MAY 12 1960

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 134

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>	Length of stay in 1b <u>10 Days</u>	c. CITY OR TOWN <u>St. Charles</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>State Hospital No. 1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>913 Madison St.</u>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Schnedler</u> Last <u>Schnedler</u>			4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>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>6-13-1888</u>	9. AGE (last birthday) <u>71</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>bank chasier-retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Fred Schnedler</u>	13b. MOTHER'S MAIDEN NAME <u>Lena Klune</u>	14. NAME OF HUSBAND OR WIFE <u>Ida Plackemeier</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>	16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT <u>State Hospital No. 1 Fulton, Mo.</u>
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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) <u>Myocardial Decompensation</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Rheumatic Heart Disease with complete block,</u>	
	DUE TO (c) <u>Cardiac enlargement &amp; mytostenosis and insufficiency.</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	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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20c. TIME OF INJURY Hour <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 <u>State Hospital No. 1</u>	COUNTY <u>    </u> STATE <u>    </u>
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21. attended the deceased from <u>4-25-60</u> to <u>5-5-60</u> Death occurred at <u>6:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>James K. Rothhusch M.D.</u>	(Degree or title)	22b. ADDRESS <u>Fulton, Mo.</u>	22c. DATE SIGNED <u>5-5-60</u>
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23a. BURIAL, CREMATION, or other disposition <u>Burial</u>	23b. DATE <u>May 8, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Charles Mo</u>
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24. FUNERAL DIRECTOR <u>Wallace Funeral Home</u>	ADDRESS <u>Fulton Mo</u>	25. DATE RECD. BY LOCAL REG. <u>May 5-1960</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 18 1988

**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 *A. R. Moore*

Licensed Embalmer No. 499

P. O. Address Fulton

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.