

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014735

FILED VS MAY 12 1960

STATE FILE NUMBER

Registration District No. 114 Primary Registration District No. 4186 Registrar's No. 16

|  |  |   |   |  |   |  |  |  |
|--|--|---|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>FRANKLIN</u>   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO.</u> b. COUNTY <u>FRANKLIN</u>                   |   |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SULLIVAN</u>  |  | Length of stay in 1b <u>5 YRS.</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>635 LAKEVIEW</u>  |  |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location) <u>635 LAKEVIEW</u>   |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>HENRY GEORGE SCHULER</u>   |  |   |   | 4. DATE OF DEATH Month Day Year<br><u>MAY 8 1960</u>   |   |  |  |  |
| 5. SEX <u>MALE</u>   |  | 6. COLOR OR RACE <u>WHITE</u>   |   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH <u>2-15-1878</u>  |  |  |
| 9. AGE (last birthday) <u>82</u>   |  | 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) <u>FARMING</u>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>                                  |  | 11. BIRTHPLACE (City and state or country) <u>JEFFRIESBURG, MO.</u> |  | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>  |  |
| 13a. FATHER'S NAME <u>JOHN HENRY SCHULER</u>   |  |   | 13b. MOTHER'S MAIDEN NAME <u>KATHERINE LOTMANN</u>                                |  |   | 14. NAME OF HUSBAND OR WIFE <u>MINNIE RHODUS SCHULER</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>498-01-6722</u>  |  | 17. INFORMANT Address <u>JAMES SCHULER SULLIVAN, MO.</u>            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Block - Bundle Branch</u><br>DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</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.<br><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>1954</u> to <u>May 8-1960</u> and last saw <sup>her</sup> him alive on <u>May 6-1960</u><br>Death occurred at <u>7:00 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |   |  |   |  |  |  |
| 22a. SIGNATURE (Degree or title) <u>Robert M. Crawford MD</u>  |  |   |   | 22b. ADDRESS <u>Sullivan Mo.</u>   |   | 22c. DATE SIGNED <u>May 10-60</u>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 23b. DATE <u>5-11-1960</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY <u>ANACONDA</u>   |   | 23d. LOCATION (City, town, or county) (State) <u>ANACONDA MO.</u>  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <u>H. M. EATON SULLIVAN, MO.</u>  |  |   | 25. DATE RECD. BY LOCAL REG. <u>5-10-60</u>                                       |  | 26. REGISTRAR'S SIGNATURE <u>Thomas G. Humphrey</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~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Harrison M. Eaton*

Licensed Embalmer No. 4192

P. O. Address Sullivan

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