

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015069

FILED VS. MAY 12 1960 140

Primary Registration District No. 3024

Registrar's No. 48

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Howard</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fayette, Mo.</b>		Length of stay in 1b <b>6 days</b>	c. CITY OR TOWN <b>Fayette</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lee Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>903 W. Davis</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANDREW</b> Middle <b>SCHENK</b> Last <b>SCHENK</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>7</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/1881</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>0</b>
IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>S.W. Bell Telephone</b>	11. BIRTHPLACE (City and state or country) <b>Rock Island, Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Jacob Schenk</b>		13b. MOTHER'S MAIDEN NAME <b>Anna B. Engel</b>		14. NAME OF HUSBAND OR WIFE <b>Nellie Blines</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>492-07-7785</b>	17. INFORMANT <b>Mrs Andrew Schenk Fayette, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b>					INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Severe jaundice - Chronic pyelonephritis</b>				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.) <b>Chronic pyelonephritis</b>			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>8:30 Jan, 1950</b> to <b>May 7, 1960</b> and last saw him alive on <b>5/7/60</b> Death occurred at <b>8:30 p.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Mrs Shaw M.D.</b>			22b. ADDRESS <b>Fayette Mo.</b>		22c. DATE SIGNED <b>5-10-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/10/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Fayette, Missouri</b>		
24. FUNERAL DIRECTOR <b>Ralph D. Case</b>		ADDRESS <b>Fayette, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-10-60</b>	26. REGISTRAR'S SIGNATURE <b>Katherine Welch</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

