

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

=60-027122

FILED VS AUG 15 1960

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER
Registrar's No. 3971

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>RAY</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ORRICK 08902</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. Joseph's Hosp.</u>			Length of stay in ^{1b} <u>17 days</u>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Forrest William Schreier, Junior</u>				4. DATE OF DEATH Month Day Year <u>August 1, 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>Sept 11, 1931</u>		9. AGE (In years last birthday) <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>		11. BIRTHPLACE (City and state or country) <u>Hodgk, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		
13a. FATHER'S NAME <u>Forrest William Schreier</u>			13b. MOTHER'S MAIDEN NAME <u>Eileen Ora Eaton</u>			14. NAME OF HUSBAND OR WIFE <u>Joyce Arlene Schreier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes 1952-Nov 1954</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>wife ORRICK, Missouri</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>Peritonitis.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 days.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Small bowel infarction from torn mesentery</u>							
		DUE TO (c) <u>CAR Accident on 7/15/60</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Multiple pelvic fractures; fracture 5th lumbar vertebra.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input checked="" 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.) <u>Truck over turned. On car</u>						
20c. TIME OF INJURY Hour Month, Day, Year <u>10:45 p.m. 7-15-60</u>									
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Country Road</u>		20f. CITY, TOWN, OR LOCATION <u>HARDIN</u>		COUNTY <u>—</u>		STATE <u>Missouri</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>5:56</u> <u>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>Alleg H. Owens Currier</u>				22b. ADDRESS <u>153 Union Hollow</u>		22c. DATE SIGNED <u>8-1-60</u>			
23a. BURIAL INFORMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>AUG. 3, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SOUTH POINT CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>ORRICK MO.</u>			
24. FUNERAL DIRECTOR <u>Wilbur Ingle ORRICK MO.</u>			25. DATE RECD. BY LOCAL REG. <u>8-2-60</u>		26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer, M.D.</u>				

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

High H. Owens

AUG 23 1960

AUG 24 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 me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Charles F. Tyler*

Licensed Embalmer No. *4534*

P. O. Address *Liberty, Mo.*

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.