

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-031240**

FILED VS AUG 29 1960

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 102

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		Length of stay in 1b <u>15 years</u>	c. CITY OR TOWN <u>Brookfield</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>511 West Canal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>511 West Canal</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Jess Frank Schaffner</u>			4. DATE OF DEATH Month Day Year <u>August 24, 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>12/20/1903</u>	9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>4</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>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brookfield Chickens</u>		11. BIRTHPLACE (City and state or country) <u>St. Catherine, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Bert Schaffner</u>		13b. MOTHER'S MAIDEN NAME <u>Rosa Farris</u>		14. NAME OF HUSBAND OR WIFE <u>Emma Schaffner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give unit or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>493-18-9535</u>		17. INFORMANT Address <u>Emma Schaffner, Brookfield, Mo.</u>			

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 <u>DO NOT KNOW</u>
IMMEDIATE CAUSE (a) <u>CARCINOMA OF COLON</u>			
DUE TO (b) _____ DUE TO (c) _____			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			

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 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 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 JULY 18 1960 to AUG 24 1960 and last saw <sup>him</sup> alive on AUG 24 1960  
Death occurred at 4:45 p on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>H. N. Potter Do.</u>	22b. ADDRESS <u>Brookfield Mo.</u>	22c. DATE SIGNED <u>8-26-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/26/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Brookfield, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Hill Funeral Home, Brookfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-26-1960</u>	26. REGISTRARS SIGNATURE <u>Walter B. Erwin</u>

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Serald F. Wadsworth*

Licensed Embalmer No. 4817

P. O. Address Brown

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.