

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-039330

FILED VS. NOV 1 1960 290

Primary Registration District No. 4427 Registrar's No. 140

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence: before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Waynesville</u>		c. CITY OR TOWN <u>Crocker</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pulaski General Hospt.</u>		d. STREET ADDRESS (If outside, give location) <u>Route #1</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Frank</u> Last <u>Schlicht</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1960</u>	
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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>11-4-1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Med.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Clinic</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>George Frank Schlicht</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Schott</u>	14. NAME OF HUSBAND OR WIFE <u>Hollie E. Schlicht</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>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mr. Sherman Schlicht, Crocker, 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: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>pulmonary cardio vascular disease</u>	
	DUE TO (c) _____	

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month _____ Day _____ Year _____
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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 _____
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21. I attended the deceased from <u>1958</u> to <u>1960</u> and last saw <sup>her</sup> him alive on <u>9-30-60</u>	
Death occurred at <u>1:40 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <u>J.E. Nichols M.D.</u>	22b. ADDRESS <u>Waynesville, Missouri</u>	22c. DATE SIGNED <u>10-7-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-2-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Webster County, Missouri</u>
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24. FUNERAL DIRECTOR <u>Rex Rainey, Springfield, Missouri</u>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>10-10-60</u>	26. REGISTRAR'S SIGNATURE <u>Eula Mae Anderson</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 4 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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed *[Handwritten Signature]*  
Licensed Embalmer No. 3312  
P. O. Address Springfield,

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.