

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041586

VS NOV 29 1960

Registration District No. 119 Primary Registration District No. 5442 Registrar's No. 30

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>GASCONADE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>GASCONADE</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richland Twp.</u>		Length of stay in 1b <u>89 yrs</u>		c. CITY OR TOWN		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>12 mi. W. of Hermann</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>12 mi. W. of Hermann</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>HUGO</u> Middle <u>PAUL</u> Last <u>SCHAEFFER</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>22</u> Year <u>1960</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU.</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>4/25/1871</u>	9. AGE (last birthday) <u>89</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>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>RFD Hermann MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		
13a. FATHER'S NAME <u>AUG. SCHAEFFER</u>			13b. MOTHER'S MAIDEN NAME <u>MARGARET BIERLEY</u>		14. NAME OF HUSBAND OR WIFE <u>MALINDA SCHAEFFER</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>NONE</u>		17. INFORMANT Address <u>MRS LORENE KELLER RFD Hermann 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		
IMMEDIATE CAUSE (a) <u>Acute renal failure</u>							<u>24 hrs.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic glomerulonephritis</u>							<u>2 yrs.</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) <u>Chronic left ventricular failure</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N <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>2/4/59</u> , to <u>11/19/60</u> and last saw <u>him</u> alive on <u>11/10/60</u> Death occurred at <u>5:52 A. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>H. H. Blum</u> (Degree or title)				22b. ADDRESS <u>Hermann, Mo.</u>		22c. DATE SIGNED <u>11/23/60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11/24/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. John's Cemetery</u>		23d. LOCATION (City, town, or county) <u>RFD Hermann</u>		23e. STATE <u>MO</u>			
24. FUNERAL DIRECTOR <u>HUGO H. BLUMER</u> ADDRESS <u>HERMANN MO</u>			25. DATE RECD. BY LOCAL REG. <u>11-23-60</u>		26. REGISTRAR'S SIGNATURE <u>Delma Uffelman</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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Roger W. Blum

Licensed Embalmer No. 5055

P. O. Address Heermann

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.