

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042964

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Registration District No. 257 Primary Registration District No. 5884 Registrar's No. 54

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>OSAGE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FOLK, MISSOURI</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>OSAGE</u> c. CITY OR TOWN <u>FOLK, MO.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY SCHULTE</u>			4. DATE OF DEATH Month Day Year <u>NOV. 27, 1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>3/12/72</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>15</u>	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Westphalia, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Henry Schulte</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Rehagen</u>		14. NAME OF HUSBAND OR WIFE <u>Katherine Kleffner</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>Felix Schulte Folk, Mo.</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>Myocardial Infarction</u> DUE TO (b) <u>Essential Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH _____		
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			
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 _____ 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 <u>July 1960</u> to <u>November 27, 1960</u> and last saw him alive on <u>September 10, 1960</u> Death occurred at <u>6.30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>James E. Stittgen D.O.</u>				22b. ADDRESS <u>Jefferson City MO.</u>			22c. DATE SIGNED <u>11-27-1960</u>	
23b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23c. DATE <u>11/30/60</u>		23d. NAME OF CEMETERY OR CREMATORY <u>St. Anthony Cemetery</u>		23e. LOCATION (City, town, or county) (State) <u>Folk, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Sylvester Rulle J C MO.</u>				25. DATE RECD. BY LOCAL REG. <u>11-30-60</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clyde Martin</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

Sylvester Quille

Licensed Embalmer No.

4321

P. O. Address

Jefferson City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.