

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-005127
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. _____ Registrar's No. 196

AMENDED

FILED VS MAR 6 1961

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Springfield</u>	
Length of stay in 1b <u>18 yrs.</u>		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>Route #4</u>		d. STREET ADDRESS (If outside, give location) <u>Route #4</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Evangeline</u> Middle <u>Naomi</u> Last <u>Schmitt</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>23</u> Year <u>1961</u>		
--------------------------------------------------------------------------------------------------------	--	--	----------------------------------------------------------------------	--	--

5. SEX <u>Female</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>5-11-1903</u>	9. AGE (last birthday) <u>57</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>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
-----------------------------------------------------------------------------------------------------------------	--------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------

13a. FATHER'S NAME <u>Charley Kates</u>	13b. MOTHER'S MAIDEN NAME <u>Lena</u>	14. NAME OF HUSBAND OR WIFE <u>Karl Schmitt</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 <u>Karl Schmitt, Springfield, Missouri</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>15 yrs.</u>
IMMEDIATE CAUSE (a) <u>Bronchial asthma</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	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
-----------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 11-60 to 2-23-61 and last saw ^{her} ~~him~~ alive on 2-20-61
Death occurred at 9:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E. L. Emmons, MD</u> (Degree or title)	22b. ADDRESS <u>Springfield, Mo.</u>	22c. DATE SIGNED <u>2-27-61</u>
-------------------------------------------------------------	-----------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-25-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brookline Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Greene Co., Mo.</u>
------------------------------------------------------------	-------------------------------	-----------------------------------------------------------------	-------------------------------------------------------------------------

25. DATE RECD. BY LOCAL REG. <u>2-2-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>
-----------------------------------------------	-----------------------------------------------------

Rainey's Chapel Springfield, Mo.
(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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

Student _____
Signature of Student Embalmer

Signed *Lee Mason*

Licensed Embalmer No. 4568

P. O. Address Springfield, 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.