

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-007918

AMENDED

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 106

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CAPE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>CAPE GIRARDEAU</u>		Length of stay in 1b <u>2 HOURS</u>	c. CITY OR TOWN <u>CHAFFEE</u>
FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>318 BLACK AVE</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>SCHEFFER</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>15</u> Year <u>1961</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1961</u>	9. AGE (last birthday) <u>—</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>CAPE GIRARDEAU, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>LAWRENCE EDWARD SCHEFFER</u>		13b. MOTHER'S MAIDEN NAME <u>ADELLA MARIE HEISSERER</u>		14. NAME OF HUSBAND OR WIFE <u>DOES NOT APPLY</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>LAWRENCE E. SCHEFFER - CHAFFEE, 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>2 hrs.</u>
IMMEDIATE CAUSE (a) <u>Failure of respiration -</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Congenital deformity of <del>the</del> left chest;</u> <u>Hydramnios and dystocia</u>		
DUE TO (c) <u>Breech presentation; cephalic deformity;</u>			
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 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 <u>—</u> a.m. <u>—</u> p.m. <u>—</u>	Month <u>—</u> Day <u>—</u> Year <u>—</u>		
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>3/15/61</u> to <u>3/15/61</u> and last saw <sup>her</sup> <del>him</del> alive on <u>3/15/61</u>		
Death occurred at <u>2:10</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>W. D. ... M.D.</u>	22b. ADDRESS <u>Chaffee, Missouri</u>	22c. DATE SIGNED <u>3/16/61</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAR. 16, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. AMBROSE CATHOLIC CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>CHAFFEE, MISSOURI</u>
24. FUNERAL DIRECTOR <u>BISPLINGHOFF FUNERAL HOME - CHAFFEE, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>3-18-61</u>	26. REGISTRAR'S SIGNATURE <u>Gene Kasten</u>

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF

W. O. Finney

**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

*Jack T. Lurnett*

Licensed Embalmer No.

4473

P. O. Address

*Chaffee, 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.