

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028962

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 11 Primary Registration District No. 200 Registrar's No. 766

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Greene</u>		a. STATE <u>Arkansas</u> COUNTY <u>Hemphstead</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>en route</u>		c. CITY OR TOWN <u>Hope</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>\$211 S. Glenstone</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) _____	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX	
First <u>Frances</u> Middle <u>Clara</u> Last <u>Schmeiker</u>		Month <u>August</u> Day <u>11</u> Year <u>1961</u>		Female	
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>5-21-1917</u>	9. AGE (last birthday) <u>44</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		Months	Days
11. BIRTHPLACE (City and state or country) <u>Hope, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>W. H. A. Schmeiker</u>		13b. MOTHER'S MAIDEN NAME <u>Fredia Nungesser</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>No</u> or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Sister</u> Address <u>Elsie Schmeiker, Hope, Arkansas.</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>24h.</u>	
IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u>					
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 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 <u>8/11/61</u> to <u>8/11/61</u> and last saw her alive on <u>8/11/61</u>		Death occurred at <u>4:30 h.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>T. E. Lockman M.D.</u> (Degree or title)		22b. ADDRESS <u>Springfield Mo.</u>		22c. DATE SIGNED <u>8/17/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-11-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Herndon-Cornelius Junr'l.</u>		23d. LOCATION (City, town, or county) (State) <u>Hope, Arkansas.</u>	
24. FUNERAL DIRECTOR <u>Rex Rainey</u> ADDRESS <u>Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-18-61</u>		26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>	

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ BY AFFIDAVIT OF

MEDICAL CERTIFICATION

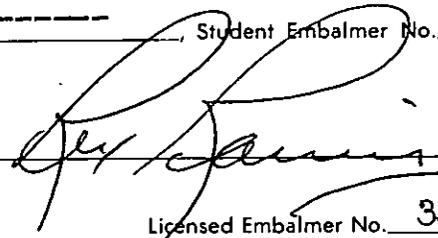
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STATEMENT BY LICENSED EMBALMER

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  _____

Licensed Embalmer No. 3312

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.