

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032358

STATE FILE NUMBER

AMENDED

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 100

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH
a. COUNTY Dent
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Salem Length of stay in 1b 1 month
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jone Nursing Home Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
STATE Missouri COUNTY Dent
c. CITY OR TOWN Salem Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 6th street Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Ben O Scheidemantel
4. DATE OF DEATH Sept. 30 1961

5. SEX male 6. COLOR OR RACE white 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 5-11-77 9. AGE (last birthday) 84
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) farmer 10b. KIND OF BUSINESS OR INDUSTRY x 11. BIRTHPLACE (City and state or country) Sacramento Calif 12. CITIZEN OF WHAT COUNTRY U S A

13a. FATHER'S NAME Andrea Scheidemantel 13b. MOTHER'S MAIDEN NAME Katie Koppitz 14. NAME OF HUSBAND OR WIFE Clara May Stites

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No x 16. SOCIAL SECURITY NO. None 17. INFORMANT Address Katie Scheidemantel St Louis Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral arterio-thrombosis, multiple. (477-942.7)
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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 2/24/47 to 9/28/61 and last saw him alive on 9/28/61
Death occurred at 3:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) *Mark M. Hart M.D.* 22b. ADDRESS Salem, Missouri 22c. DATE SIGNED 10/2/61

23a. BURIAL, CREMATION, REMOVAL (Specify) burial 23b. DATE Oct 3-61 23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cem 23d. LOCATION (City, town, or county) Salem Mo (State)

24. FUNERAL DIRECTOR ADDRESS Spencer Funeral Home Inc 25. DATE RECD. BY LOCAL REG. 10/2/61 26. REGISTRAR'S SIGNATURE *M. M. Hart, M.D.*

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 Carl D. Spencer

Licensed Embalmer No. 9370

P. O. Address Palmer

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.