

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007615

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 55

FILED FEB 28 1962

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		Length of stay in 1b 1 mo.	c. CITY OR TOWN St. Peters, Mo. Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1/2 mi. so. St. Peters Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Clem L. Schwendeman			4. DATE OF DEATH Febr. 16, 1962		
First Middle Last			Month Day Year		

5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1887	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) St. Peters, Mo.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Frank Schwendeman	13b. MOTHER'S MAIDEN NAME Kohlenhoeffler	14. NAME OF HUSBAND OR WIFE Louise Schwendeman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	17. INFORMANT Louise Schwendeman, St. Peters, Mo.
Address	

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
IMMEDIATE CAUSE (a) Carcinoma stomach with		18 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) general metastases	
	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
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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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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
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21. I attended the deceased from Aug. - 1949 to Feb. 16 - 62 and last saw him alive on Feb. 16 - 62
Death occurred at 745 2. Ave. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Lawrence H. Schneider, M.D.</i>	22b. ADDRESS <i>St. Charles, Mo.</i>	22c. DATE SIGNED <i>2-17-62</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 2-19-62	23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery	23d. LOCATION (City, town, or county) (State) St. Peters, Mo.
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24. FUNERAL DIRECTOR Geo. Stiefvater, St. Peters, Mo.	25. DATE RECD. BY LOCAL REG. 2/17/62	26. REGISTRAR'S SIGNATURE <i>Harold Wilson</i>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

DATE AMENDED
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MAY 15 1962

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 Jerry A. Davis
Licensed Embalmer No. 5139

P. O. Address O Fallon, 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.