

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-010148

FILED APR 5 1962 Primary Registration District No. 3010 Registrar's No. 148

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

6168
21000

3
4 0
5 1
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7 0
8 2
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11 115
12 2-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. 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 lb <u>4 hrs.</u>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Francis Hosp.</u>		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First <u>ZENO</u> Middle <u>MICHAEL</u> Last <u>SCHAEFER</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1962</u>	
5. SEX <u>Male</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>Jan 8, 1917</u>
10a. USUAL OCCUPATION (Give kind of work done during best of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (City and state or country) <u>Oran, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Lawrence Schaefer</u>		13b. MOTHER'S MAIDEN NAME <u>Matilda Bullinger</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>		17. INFORMANT <u>Mrs Barbara Schaefer</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Cerebral Concussion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Subdural Hematoma</u>			
DUE TO (c) <u>Epidural Hematoma</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of Skull</u>		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 checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Fell out of a tree</u>	
20c. TIME OF INJURY Hour <u>1:30</u> p.m. Month, Day, Year <u>March 24, 1962</u>		20f. CITY, TOWN, OR LOCATION <u>Scott City, Mo</u>	
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.)	
21. I attended the deceased from <u>March 24, 1962</u> to <u>March 24, 1962</u> and last saw him <u>alive</u> on <u>March 24, 1962</u>		Death occurred at <u>3:22 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Walter C. Kasten M.D.</u>		22b. ADDRESS <u>937 Broadway Copo Memorial</u>	
22c. DATE SIGNED <u>3-27-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/27/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Joseph's Cem</u>	
24. FUNERAL DIRECTOR <u>BISPLINGHOFF FUNERAL HOME</u>		23d. LOCATION (City, town, or county) (State) <u>Scott City, Missouri</u>	
25. DATE RECD. BY LOCAL REG. <u>3-29-62</u>		26. REGISTRAR'S SIGNATURE <u>Walter C. Kasten</u>	

3964 MAY 2 1962

MAY 2 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 Oliver Arnold

Licensed Embalmer No. 4470

P. O. Address Illus New

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.