

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-023760

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 170 Primary Registration District No. 3093 Registrar's No. 134

FILED JUL 2 1962

VS 300
Rev. 4/59

10535

20530

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Length of stay in lb <u>7 days</u>	c. CITY OR TOWN <u>Conway</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wallace Hosp.</u>		inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside give location) <u>No St. address</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles E. Schubbe</u>			4. DATE OF DEATH Month Day Year <u>June 27 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>4/15/1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>62</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
13a. FATHER'S NAME <u>William Schubbe</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>	12. CITIZEN OF WHAT COUNTRY <u>Genoa City Wisconsin U.S.A.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes World War I</u>		16. SOCIAL SECURITY NO. 	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u>		17. INFORMANT Address <u>Loretta Schubbe Conway Mo</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</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 checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <u>None</u>		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>6/20/62</u> to <u>6/27/62</u> and last saw her/him alive on <u>6/27/62</u> Death occurred at <u>6:30 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. J. E. Fisher M.D.</u>		22b. ADDRESS <u>Lebanon, Mo</u>	
22c. DATE SIGNED <u>6/28/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/30/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cemetery Conway Mo.</u>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS <u>Dorsey M. Howe Lebanon Mo.</u>		25. DATE RECD. BY LOCAL REP. <u>6-29-1962</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Hays</u>

USE BLACK INK OR TYPEWRITER RIBBON

2961 8 707 SA

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 Dorsey M. Howe

Licensed Embalmer No. 42220

P. O. Address Lebanon, 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.

Permit issued 6-29-1962 M.D.M.