

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-024296

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 2058 Registrar's No. 182

FILED JUL 12 1962

VS 300  
Rev. 4/59

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| 1  | 0928 |
| 2  | 0928 |
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| 9  | 4200 |
| 10 |      |
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| 12 | 90-0 |
| 13 | 4-0  |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Charles</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>              |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>  |   | c. CITY OR TOWN <u>St. Charles</u>  |  |
| Length of stay in lb <u>LIFE</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>Residence</u>  |   | d. STREET ADDRESS (If outside, give location) <u>224 Transit</u>  |  |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Julius F. Schoene</u>   |   |   | 4. DATE OF DEATH Month Day Year<br><u>July 4 1962</u>  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>   | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-13-1881</u>  |
| 9. AGE (last birthday) <u>81</u>  |   | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>  | 11. BIRTHPLACE (City and state or country) <u>St. Charles Co., Mo.</u>   |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u>  |   | 13a. FATHER'S NAME <u>William Schoene</u>   |  |
| 13b. MOTHER'S MAIDEN NAME <u>Louise Kipp</u>  |   | 14. NAME OF HUSBAND OR WIFE <u>None</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>  |   | 16. SOCIAL SECURITY NO. <u>None</u>   | 17. INFORMANT Address <u>Edgar Schoene, Orchard Farm, Mo.</u>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease (myocardium)</u>  |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>3 dn.</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Chronic bronchitis + bronchiectasis</u>   |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><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 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>12-29-59</u> to <u>7-4-62</u> and last saw him alive on <u>7-3-62</u><br>Death occurred at <u>6 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |
| 22a. SIGNATURE (Degree or title) <u>J. F. Combs, M.D.</u>   |   | 22b. ADDRESS <u>114 N. Main St. Charles, Mo.</u>  | 22c. DATE SIGNED <u>7-5-62</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE <u>July 6, 1962</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery, Orchard Farm, Mo.</u>  | 23d. LOCATION (City, town, or county) (State) _____  |
| 24. FUNERAL DIRECTOR ADDRESS <u>Arthur C. Baue, St. Charles, Mo.</u>  | 25. DATE RECD. BY LOCAL REG. <u>7/6/62</u>  | 26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>  |  |

**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 Annie L. Pickering

Licensed Embalmer No. 5189

P. O. Address St. Charles, 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.