

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033855

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1057

FILED SEP 24 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF *O.W.D. Craig, M.D.* MEDICAL CERTIFICATION

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>                 |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Joseph</b>  |   | Length of stay in 1b<br><b>most of life</b>   | c. CITY OR TOWN <b>St. Joseph</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Missouri Methodist Hosp.</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>609 So. 8th St.</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>     |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>WILLIAM SCHAFER</b>  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>September 11, 1962</b>  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/15/1889</b>   |
| 9. AGE (last birthday)<br><b>73</b>   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | 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)<br><b>carpenter</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>Buchanan County, Mo.</b>  |
| 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |   | 13a. FATHER'S NAME<br><b>unknown</b>  |  |
| 13b. MOTHER'S MAIDEN NAME<br><b>unknown</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Mrs. Edith Greer, Gower, Missouri</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   | 17. INFORMANT<br><b>Mrs. Edith Greer, Gower, Missouri</b>  |
| 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) <b>Acute Cerebral Hemorrhage</b>  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 hours</b>   |
| 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)   |   |   | 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?<br>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<br>Hour e.m. p.m.<br>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 <b>9/11/62</b> to <b>9/11/62</b> and last saw him alive on <b>9/11/62</b><br>Death occurred at <b>6:40 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |
| 22a. SIGNATURE<br><i>O.W.D. Craig, M.D.</i>   |   | 22b. ADDRESS<br><b>Social Welfare Board<br/>10th &amp; Olive, St. Joseph, Mo.</b>   | 22c. DATE SIGNED<br><b>9/12/62</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>   | 23b. DATE<br><b>9/12/1962</b>   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City, town, or county) (State)<br><b>Gower, Missouri</b>  |
| 24. FUNERAL DIRECTOR<br><i>Horton-Bowman</i>  | ADDRESS<br><b>St. Joseph, Mo.</b>   | 25. DATE RECD. BY LOCAL REG.<br><b>Sept. 19, 1962</b>   | 26. REGISTRAR'S SIGNATURE<br><i>Mrs. Clark Goodell</i>   |

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 9/12/62

**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 William Specializing

Licensed Embalmer No. 4535

P. O. Address St Joseph 7000

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.