

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-042115

STATE FILE NUMBER

Registration District No. 93 Primary Registration District No. _____ Registrar's No. 62-72

FILED DEC 4 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0290

2 0290

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grant TWP</u>		c. CITY OR TOWN <u>Golden City RT2</u>	
Length of stay in 1b <u>yrs</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 mi east of Dudenville</u>		d. STREET ADDRESS (If outside, give location) <u>1 mi east of Dudenville</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Bernice Schroeder</u>			4. DATE OF DEATH Month Day Year <u>Nov. 24 1962</u>
5. SEX <u>Female</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>Aug 23 1928</u>
9. AGE (last birthday) <u>39</u>		IF UNDER 1 YEAR Months Days <u>3 1</u>	IF UNDER 24 HR Hours Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Dade Co Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Charles Tubaugh</u>	
13b. MOTHER'S MAIDEN NAME <u>Grace Casteel</u>		14. NAME OF HUSBAND OR WIFE <u>Oswald Schroeder</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 <u>Oswald Schroeder</u>		Address <u>Golden City Mo rt2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>12 gauge gun shot to medial forehead.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Poor health.</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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>Self inflicted, wound.</u>	
20c. TIME OF INJURY Hour a.m. Month, Day, Year <u>12:30 pm 11-24-62</u>			
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>after death.</u> and last saw her/him alive on _____		Death occurred at <u>12:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>W.R. Allison Coroner</u>		22b. ADDRESS <u>Greenfield Mo</u>	22c. DATE SIGNED <u>11-24-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov 27 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dudenville</u>	23d. LOCATION (City, town, or county) (State) <u>Dudenville Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Allison Funeral Home Greenfield Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11/28/1962</u>	26. REGISTRAR'S SIGNATURE <u>J.C. Canada</u>

USE BLACK INK OR TYPEWRITER RIBBON
W.R. Allison, Coroner

DEC 6 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: W. P. Allison

Licensed Embalmer No. 4404

P. O. Address Greenville, S.C.

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.