

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-042907

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5649 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 16 1962

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

H. OWBIS

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|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>California</u> b. COUNTY <u>Alameda</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> | | Length of stay in lb <u>10 days</u> | c. CITY OR TOWN <u>SAN FRANCISCO</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>131 South Lawn</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>444 Valverde Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>FRANCIS</u> Middle <u>A.</u> Last <u>Schmedinghoff</u> | | | 4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1962</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cauc.</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 24, 1892</u> |
| 9. AGE (last birthday) <u>70</u> | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR. Hours _____ Min _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Controller</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>H.L. HUGHSON CO.</u> | 11. BIRTHPLACE (City and state or country) <u>Chicago, Illinois</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>August Schmedinghoff</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Murphy</u> | | 14. NAME OF HUSBAND OR WIFE <u>Cecilia Schmedinghoff</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.I.</u> | | 16. SOCIAL SECURITY NO. <u>[Redacted]</u> | |
| 17. INFORMANT <u>Joseph Schmedinghoff</u> | | Address <u>5732 Holmes</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Dist Heart V A Heart</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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Joseph Schmedinghoff</u> (Degree or title) | | 22b. ADDRESS <u>157 Union Station</u> | 22c. DATE SIGNED <u>11-7-62</u> (State) |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>November 7, 1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Golden Gate National</u> | 23d. LOCATION (City, town, or county) <u>San Francisco California</u> |
| 24. FUNERAL DIRECTOR <u>Muehleback</u> | ADDRESS <u>6800 TROOST</u> | 25. DATE RECD. BY LOCAL REG. <u>11-7-62</u> | 26. REGISTRAR'S SIGNATURE <u>Ruth Long</u> |

USE BLACK INK OR TYPEWRITER RIBBON

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 R. E. Nichols

Licensed Embalmer No. 4997

P. O. Address K. C. MD

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.