

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 806

FILED JAN 13 1949

BIRTH NO. _____ REG. DIST. NO. 114 PRIMARY REG. DIST. NO. 486 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sullivan</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SULLIVAN</u>	
c. LENGTH OF STAY (in this place) <u>years</u>		d. STREET ADDRESS (If rural, give location) <u>176 E. Euclid Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>FRED</u>		b. (Middle) _____ c. (Last) <u>SCHATZ</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 6 1949</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT 13, 1922</u>
9. AGE (In years last birthday) <u>26</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>23</u>	
11. BIRTHPLACE (State or foreign country) <u>SULLIVAN MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LABOR</u>	
13a. FATHER'S NAME <u>GEORGE SCHATZ</u>		13b. MOTHER'S MAIDEN NAME <u>SOPHIA BAUMANN</u>	
14. NAME OF HUSBAND OR WIFE <u>EDITH SCHATZ</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. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>Edith Schatz</u>		ADDRESS <u>Sullivan Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary sclerosis</u>		DUE TO (c) _____	
Conditions contributing to the death but not related to the disease or condition causing death. <u>H2O11</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Dec 14, 1948</u> , to <u>Jan 6, 1949</u> that I last saw the deceased alive on <u>Dec 30, 1948</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>de la Toure M.D.</u> (Degree or title)		23b. ADDRESS <u>Sullivan, Mo</u>	
23c. DATE SIGNED <u>1/7/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24b. DATE <u>Jan 9, 1949</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>		24d. LOCATION (City, town, or county) (State) <u>Sullivan Mo</u>	
DATE REC'D BY LOCAL REG. <u>1-7-49</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Tractor</u> ADDRESS <u>49</u>	
REGISTRAR'S SIGNATURE <u>Ed. Tractor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. P. Shaffer</u> ADDRESS <u>Sullivan Mo</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JAN 11 1949

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
Student Embalmer

Signed

Edgar W. Laffoon

Licensed Embalmer No. *3394*

P. O. Address *Sullivan 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 this body is not embalmed, fact should be so stated above.