

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 17 1950

BIRTH NO. _____ REG. DIST. NO. 77 PRIMARY REG. DIST. NO. 3016 Registrar's No. 63

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Osage</u>	
b. CITY OR TOWN <u>Jefferson City</u> (If outside corporate limits, write RURAL and give township)		c. CITY OR TOWN <u>Meta</u> (If outside corporate limits, write RURAL and give township)	
c. LENGTH OF STAY (in this place) <u>1 day</u>		d. STREET ADDRESS <u>0760</u> (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>FRED</u> b. (Middle) _____ c. (Last) <u>SCHALLERT</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 12 1950</u>
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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>October 24 1877</u>	9. AGE (In years) (last birthday) <u>72</u> (Months) <u>4</u> (Days) <u>16</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Milling</u>	11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo. U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Adolph Schallert</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Schlieff</u>	14. NAME OF HUSBAND OR WIFE <u>Johanna Schallert</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or date of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Johanna Schallert</u> ADDRESS <u>Meta</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
	ANTECEDENT CAUSES *Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Mal-nutrition</u> DUE TO (c) <u>Psychosis (financial)</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>(Supplementary report)</u>		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from Mar 11 1950 to Mar 12 1950, that I last saw the deceased alive on Mar 11 1950, and that death occurred at 7:55 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. A. Osseman M.D.</u>	23b. ADDRESS <u>Jeff. City - Mo</u>	23c. DATE SIGNED <u>3-12-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>March 15</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Cecilia Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Meta Mo.</u>
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DATE REC'D BY LOCAL REG. <u>March 14 - 50</u>	REGISTRAR'S SIGNATURE <u>R.P. Dorrie M.D. - NR. 68</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman H. Strop</u> ADDRESS <u>Meta Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

300
400

RECEIVED
MAR 15 1950
District Health Officer No. 9,
District File Number

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 *Herman H. Sharp*

Licensed Embalmer No. *2924*

P. O. Address *Meta Md*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.