

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20791

State File No. _____

FILED JUN 29 1953

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 688

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	c. LENGTH OF STAY (In this place) <u>7 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Monroe Township</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>R #1 Cosby, Mo.</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>Adolph</u>	b. (Middle) <u>G.</u>	c. (Last) <u>Schneider</u>	(Month) <u>June</u>	(Day) <u>16,</u>	(Year) <u>1953</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>November 6, 1867</u>	9. AGE (In years last birthday) <u>85</u>	10. MONTHS <u>1</u>	11. DAYS <u>1</u>	12. HOURS <u>1</u>	13. MINUTES <u>1</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Andrew County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>John Schneider</u>	13b. MOTHER'S MAIDEN NAME <u>Anna B. Schindler</u>	14. NAME OF HUSBAND: OR WIFE <u>Lisette Schneider</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and date of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Lisette Schneider</u>		ADDRESS <u>R#1. Cosby, Mo.</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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	<u>Pres nephritis -</u>		<u>5-1-53</u>
ANTECEDENT CAUSES	DUE TO (b)		<u>Prostatectomy - 5-4-53</u>
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	<u>Prostatectomy</u>		<u>6/2x</u>
DUE TO (c)	<u>Terminal Hypertensive Pneumonia</u>		<u>- 5 days.</u>
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>5-4-53</u>	19b. MAJOR FINDINGS OF OPERATION <u>Enucleation of Prostate Gland</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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 5-1-, 1953, to 6-16-, 1953, that I last saw the deceased alive on 6-15-, 1953, and that death occurred at 6:15A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Wilbur B. Kelley MD</u>	(Degree or title)	23b. ADDRESS <u>Savannah, Missouri</u>	23c. DATE SIGNED <u>6-17-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 18, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Cosby, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>June 25, 1953</u>	REGISTRAR'S SIGNATURE <u>Katherine M. Allison</u>	485	25. FUNERAL DIRECTOR'S SIGNATURE <u>Amickhoff - Selman</u>	ADDRESS <u>St. Joseph, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 17 1957

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 Albert R. Harrington

Licensed Embalmer No. 3258 Missouri.

P. O. Address St. Joseph, Missouri.

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.