

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

25665

State File No.

0.300
0.48

Green
FILED AUG 14 1953

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 284

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY OR TOWN <u>Hannibal</u>		c. CITY OR TOWN <u>Hannibal</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>515 So. Main St.,</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ethel</u>	b. (Middle)	c. (Last) <u>Schumm</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>8-3-1953</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10/9/1911</u>	9. AGE (In years last birthday) <u>41</u>	IF UNDER 1 YEAR Months <u>9</u>	IF UNDER 24 HRS. Hours <u>0</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Intern'l Shoe Co</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Bay Island, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Joseph Strothoff</u>	13b. MOTHER'S MAIDEN NAME <u>Birdie Sinclair</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Frank Youse, Clarence, Mo.</u>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>7 days</u> <u>10 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Care Pulmonale</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Bronchopneumonia</u> DUE TO (c) <u>Chronic Bronchiectasis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>526X</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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 2-2-48, 19 , to 8-3-53, 19 , that I last saw the deceased alive on 8-3-53, 19 , and that death occurred at 11:15P., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>100 N. Sixth, Hannibal, Mo.</u>	23c. DATE SIGNED <u>8-4-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8/5/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>8/4/53</u>	REGISTRAR'S SIGNATURE <u>N E M Lucke</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Hannibal Mo</u>
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189-0 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED AUG 10 1953
MARION CO. HEALTH DEPT.
DATE FILED AUG 12 1953

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.....

Licensed Embalmer No. 3889

P. O. Address.....

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.