

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **3674**

FILED JAN 22 1954

BIRTH NO.		REG. DIST. NO. 335		PRIMARY REG. DIST. NO. 4422		Registrar's No. 45	
1. PLACE OF DEATH a. COUNTY SCOTT <i>1000</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY SCOTT			
b. CITY (If outside corporate limits, write RURAL and give township) ORAN		c. LENGTH OF STAY (In this place) 4 YRS.		c. CITY (If outside corporate limits, write RURAL and give township) ORAN <i>1000</i>		d. STREET ADDRESS (If rural, give location) ORAN <i>0</i>	
3. NAME OF DECEASED a. (First) CHARLES (Type or Print)				b. (Middle) SCHOTT		c. (Last) SCHOTT	
4. DATE OF DEATH (Month) (Day) (Year) JAN. 10 1954		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH OCTOBER 17 1882		9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months		IF UNDER 2 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MISSOURI <i>0</i>	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13a. FATHER'S NAME LEO SCHOTT		13b. MOTHER'S MAIDEN NAME VICTORIA BRUCKER	
14. NAME OF HUSBAND OR WIFE OTILIA SCHOTT				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME OTILIA SCHOTT				ADDRESS ORAN MO.			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes Mellitis				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)					
DUE TO (c)							
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				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)		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 Mr. Charles Schott , 1952, to 12/30, 1952 , that I last saw the deceased alive on 12/28, 1952 , and that death occurred at 9:45 P. M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J. A. Clinch M.D.				23b. ADDRESS Oran Mo.		23c. DATE SIGNED 1/4/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JAN. 13 1954		24c. NAME OF CEMETERY OR CREMATORY NEW GUARDIAN ANGELS		24d. LOCATION (City, town, or county) (State) ORAN MO.	
DATE REC'D BY LOCAL REG. 1-14-54		REGISTRAR'S SIGNATURE Thos. F. Bragginghoff <i>445</i>		25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith		ADDRESS ORAN, MO.	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 1-16-54

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 184-12

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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 Earl J. Smith
.....
Licensed Embalmer No. 2676

P. O. Address Orew, 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.

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