

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18528**

FILED JUL 7 1954

BIRTH NO. _____ REG. DIST. NO. 119 PRIMARY REG. DIST. NO. 5435 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY GASCONADE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GASCONADE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL - BOEUF	c. LENGTH OF STAY (in this place) 23 7/8	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HERMANN	
d. FULL NAME OF HOSPITAL OR INSTITUTION 15 MILES S OF HERMANN		d. STREET ADDRESS (If rural, give location) 203 SCHILLER ST.	

3. NAME OF DECEASED (Type or Print) a. (First) AMANDA b. (Middle) HELENA c. (Last) SCHANNUTH			4. DATE OF DEATH (Month) (Day) (Year) JUNE 30, 1954		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH SEP. 26, 1882		9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) VOLGA CITY, IOWA		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME HENRY OCHSNER		13b. MOTHER'S MAIDEN NAME IDA KOEHN		14. NAME OF HUSBAND OR WIFE CHRISTIAN SCHANNUTH	
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. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS SADIE FRAZIER, MEMPHIS, TENNESSEE	

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		INTERVAL BETWEEN ONSET AND DEATH 1 hr.
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute circulatory collapse		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Severe myocardial enlargement DUE TO (c) Aortic insufficiency		
11. 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) (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 Jan. 1, 1953 to June 30, 1954, that I last saw the deceased alive on June 30, 1954, and that death occurred at 5:50 P.M. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W.D. 2	23b. ADDRESS Hermann, Mo	23c. DATE SIGNED 7/2/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 3, 1954	24c. NAME OF CEMETERY OR CREMATORY HERMANN CITY Cem.	24d. LOCATION (City, town, or county) (State) HERMANN MO
DATE REC'D BY LOCAL REG. 7-2-54	REGISTRAR'S SIGNATURE Delma Gerken	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hugh H. Bremer, Hermann, Mo.	

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

6370

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 _____

Hugo L. Dennis

Licensed Embalmer No. 3160

P. O. Address Hermann, 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.