

FILED SEP 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30327

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 865-A

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD</u>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>R7D</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1731 Summit</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
STREET ADDRESS <u>SEYMOUR MO 11201</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>BARBARA E.</u> b. (Middle) <u>SCHPOEDER</u> c. (Last) <u></u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 14, 1954</u>	
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>Nov. 7, 1868</u>
9. AGE (in years, months, days) <u>85</u>		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) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>BRIODUTE GERMANY</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13a. FATHER'S NAME <u>JOHN DARRINE</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>FRED C. (DEC)</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT'S SIGNATURE OR NAME <u>ROTH HOSINER</u> ADDRESS <u>SPRINGFIELD MO</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardio-Renal-Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH _____	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused 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) <u>442X</u>	
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 from <u>9-4</u> , 19 <u>54</u> , to <u>9-4</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>9-7</u> , 19 <u>54</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Thy Keth</u> (Doctor or M.D.)		23b. ADDRESS <u>Springfield Mo</u>	23c. DATE SIGNED <u>9-15-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9-26-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fordland</u>	24d. LOCATION (City, town, or county) (State) <u>Fordland MO</u>
DATE REC'D BY LOCAL REG. <u>9-20-54</u>	REGISTRAR'S SIGNATURE <u>Edna Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Bergman</u> ADDRESS <u>Seymour Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed... *Don G. Ferrill*

Licensed Embalmer No. *4847*

P. O. Address *Manfield, W.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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