

FILED JUL 9 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19580

State File No. ....

|  |  |  |             |   |                           |   |  |  |  |   |  |  |  |                           |  |
|--|--|--|-------------|---|---------------------------|---|--|--|--|---|--|--|--|---------------------------|--|
| BIRTH NO. ....   |  | REG. DIST. NO. <u>38</u>   |             | PRIMARY REG. DIST. NO. <u>2006</u>  |                           | Registrar's No. <u>209</u>  |  |  |  |   |  |  |  |                           |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>  |  |  |             | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>-a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u> |                           |   |  |  |  |   |  |  |  |                           |  |
| b. CITY OR TOWN <u>Columbia</u>  |  | c. LENGTH OF STAY (in this place) <u>1 day</u>   |             | c. CITY OR TOWN <u>Sedalia</u>  |                           | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |  |  |   |  |  |  |                           |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>   |  |  |             | e. STREET ADDRESS (If rural, give location) <u>2235 E. 12th St<br/>Missouri 0807</u>  |                           |   |  |  |  |   |  |  |  |                           |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>Maggie</u>   |  |  | b. (Middle) |   | c. (Last) <u>Schmidt.</u> |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>7 1 1956</u> |  |  |   |  |  |  |                           |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>  |             | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>  |                           | 8. DATE OF BIRTH <u>Feb. 12, 1881</u>   |  | 9. AGE (In years last birthday) <u>75</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>Housewife</u>   |  |  |             | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>   |                           | 11. BIRTHPLACE (City and State, or Foreign Country) <u>Marion County, Indiana</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |  |  |  |                           |  |
| 13a. FATHER'S NAME <u>James Ashbrook</u>   |  |  |             | 13b. MOTHER'S MAIDEN NAME <u>Nancy Payne</u>  |                           |   |  | 14. NAME OF HUSBAND OR WIFE <u>Edward A. Schmidt</u>             |  |   |  |  |  |                           |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if unknown) (If yes, give date of service) <u>No</u>   |  |  |             | 16. SOCIAL SECURITY NO. <u>None</u>   |                           | 17. INFORMANT'S SIGNATURE AND NAME AND ADDRESS <u>Edward A. Schmidt, 2235 E. 12th St, Sedalia, Mo.</u>                            |  |  |  |   |  |  |  |                           |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>INTESTINAL OBSTRUCTION</u><br>ANTECEDENT CAUSES <u>Inflammation Stricture of Colon</u><br>DUE TO (b) <u>1 yr.?</u><br>DUE TO (c) <u>5705</u><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |             |   |                           |   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>   |  |                           |  |
| 19a. DATE OF OPERATION <u>6-30-56</u>  |  | 19b. MAJOR FINDINGS OF OPERATION <u>Obstruction of ascending colon and hepatic flexure</u>   |             |   |                           |   |  |  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |  |                           |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>   |  | 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 from <u>6-30, 1956</u> , to <u>7-1, 1956</u> , that I last saw the deceased alive on <u>7-1, 1956</u> , and that death occurred at <u>12:40 p.m.</u> , from the causes and on the date stated above. |  |  |             |   |                           |   |  |  |  |   |  |  |  |                           |  |
| 23a. SIGNATURE <u>D. Bernette, M.D.</u>  |  |  |             | (Degree or title)   |                           |   |  | 23b. ADDRESS <u>Columbia, Missouri</u>                           |  |   |  | 23c. DATE SIGNED <u>7-1-56</u>   |  |                           |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>   |  | 24b. DATE <u>July 1 1956</u>   |             | 24c. NAME OF CEMETERY OR CREMATORY  |                           |   |  | 24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo.</u> |  |   |  |  |  |                           |  |
| DATE REC'D BY LOCAL REG. <u>July 1 1956</u>  |  |  |             | REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>   |                           |   |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Wesley Evening</u>           |  |   |  | ADDRESS <u>Sedalia</u>   |  |                           |  |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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..... *R. E. Baker*

Licensed Embalmer No. *241*

P. O. Address..... *Madison*

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.