

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **11781**

FILED APR 8 - 1957

BIRTH NO. _____		REG. DIST. NO. <b>328</b>		PRIMARY REG. DIST. NO. <b>3073</b>		Registrar's No. <b>11</b>		
1. PLACE OF DEATH a. COUNTY <b>SCOTT</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>SCOTT</b>				
b. CITY (If outside corporate limits, write RURAL and give township) <b>CHAFFEE</b>		c. LENGTH OF STAY (in this place) <b>5 YRS.</b>		c. CITY OR TOWN <b>CHAFFEE 100</b>		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 <b>FRISCO RLY. YARDS</b>				e. STREET ADDRESS (If rural, give location) <b>NORTH FRISCO STREET</b>				
3. NAME OF DECEASED (Type or Print) <b>LUDONIS FRANK SCHMITT</b>			a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH <b>MARCH 20, 1957</b>		(Month) (Day) (Year)		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		
7. MARRIED, NEVER MARRIED, <b>2</b> WIDOWED, DIVORCED (Specify)		<b>WIDOWED</b>		8. DATE OF BIRTH <b>NOV. 2, 1882</b>		9. AGE (in years last birthday) <b>74</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER (RET.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>(NEAR) NEW HAMBURG, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>RUDOLPH SCHMITT</b>		13b. MOTHER'S MAIDEN NAME <b>CATHERINE WEBER</b>		14. NAME OF HUSBAND OR WIFE <b>ANNA MARY MARGARET SCHMITT</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>494-01-8490</b>		17. INFORMANT'S SIGNATURE OR NAME <b>MRS. LOUIE SCHEETER - CHAFFEE, MO.</b>				
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) <b>Amputation R. arm at shoulder + Rt. foot at ankle - Crushed chest - Broken neck.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>0</b>						
ANTECEDENT CAUSES		DUE TO (b) _____						
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) <b>Deafness</b>						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>802X</b>						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>-35</b>				20. AUTOPSY? <input type="checkbox"/>		
YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <b>FRISCO R.R. TRACKS.</b>		21c. (CITY, TOWN, OR TOWNSHIP) <b>CHAFFEE</b> (COUNTY) <b>SCOTT</b> (STATE) <b>MO.</b>		
21d. TIME OF INJURY <b>March, 20 - 57 - 1 1/2 p.m.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Man walked in front of switch engine &amp; hit by engine</b>				
22. I hereby certify that I attended the deceased from <b>First call after death</b> , 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>7:17 A.M.</b> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>Thelma C. Buchhorpe, M.D. Health Officer.</b>				23b. ADDRESS <b>Benton, Mo.</b>		23c. DATE SIGNED <b>3-23-57</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>MAR. 22, 1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>ST. AMBROSE CATHOLIC CEM.</b>		24d. LOCATION (City, town, or county) (State) <b>CHAFFEE, MISSOURI</b>		
DATE REC'D BY LOCAL REG. <b>3-29-57</b>		REGISTRAR'S SIGNATURE <b>Mrs. Fred Bisplinghoff</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>BISPLINGHOFF FUNERAL HOME - CHAFFEE, MO.</b>				
				ADDRESS _____				

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

445  
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DATE RECEIVED APR 1 1957

SCOTT CO. HEALTH DEPT.

CO. FILE NO. 457-66

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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.....  
Signature of Student Embalmer

Signed Jack J. Burnett

Licensed Embalmer No. 4473

P. O. Address Chaffee, Md

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.