

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16586

State File No.

FILED JUN 10 1957

S. No. 300
v. 10.48

BIRTH NO. _____ REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 3017 Registrar's No. 70

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cooper	
b. CITY (If outside corporate limits, write RURAL and give town) Boonville		c. LENGTH OF STAY (In this place) 6 Days.	c. CITY OR TOWN Boonville
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		STREET ADDRESS (If rural, give location) 628 Fourth St.	

3. NAME OF DECEASED (Type or Print) a. (First) Charles	b. (Middle)	c. (Last) Schieberl	4. DATE OF DEATH (Month) (Day) (Year) June 3 1957
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Dec. 23rd 1873	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	10b. KIND OF BUSINESS OR INDUSTRY House & Sign Painting	11. BIRTHPLACE (City and State or Foreign Country) Boonville, Missouri.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Martin Schieberl	13b. MOTHER'S MAIDEN NAME Dorothy Schiller	14. NAME OF HUSBAND OR WIFE ---
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 497-14-6148A	17. INFORMANT'S SIGNATURE OR NAME Mrs. Edith Chrismann	ADDRESS Boonville, Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarct		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Coronary Occlusion		
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 H201	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 5:30, 1957, to 6-3-, 1957, that I last saw the deceased alive on 6-2-, 1957, and that death occurred at 12:30 A m., from the causes and on the date stated above.

23a. SIGNATURE T. C. Beckett md	(Degree or title)	23b. ADDRESS Boonville Mo	23c. DATE SIGNED 6-5-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 6 1957	24c. NAME OF CEMETERY OR CREMATORY Walnut Grove	24d. LOCATION (City, town, or county) (State) Boonville, Missouri.
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DATE REC'D BY LOCAL REG. 6-6-57	REGISTRAR'S SIGNATURE S. Cooper	25. FUNERAL DIRECTOR'S SIGNATURE Goodman & Boller	ADDRESS Boonville, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

321

JUL 8 1961

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... *William W. Wood*

Licensed Embalmer No. *4539*.....

P. O. Address *Bloomville, Pa.*.....

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.