

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29013

STATE FILE NUMBER

FILED AUG 22 1957

Registration District No. 280 Primary Registration District No. 4423 Registrar's No. 51

1. PLACE OF DEATH a. COUNTY <b>Platte</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Platte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Weston</b> <i>Weston</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Weston</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <i>5838</i> <input checked="" type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Schaback</b> Last <b>Schaback</b>			4. DATE OF DEATH Month <b>August</b> Day <b>16</b> , Year <b>1957</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1869</b>	9. AGE (In years to birthday) <b>88</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b> <i>retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	11. BIRTHPLACE (City and state or country) <b>Weston, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Schaback</b>			14. MOTHER'S MAIDEN NAME <b>Frances Ballinger</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Mrs M. M. Ohlhausen Weston, Mo.</b>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia, Dehydration, Starvation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>one yr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cancer of stomach, wide metastasis.</b>		<b>one year</b>
DUE TO (c) <b>Causes unknown</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>XXXXXXXXXX</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <b>XXXXXXXXXX</b>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>XXXXXXXXXX</b>
20c. TIME OF INJURY Hour <b>X</b> Month <b>X</b> Day <b>X</b> Year <b>X</b> a. m. <b>X</b>	<b>XXXXXXXXXX</b>

20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>XXXXXXXXXX</b>	20f. CITY, TOWN, OR LOCATION <b>Weston</b>	COUNTY <b>Missouri</b>	STATE <b>Missouri</b>
21. I attended the deceased from <b>Nov. 13, 1956</b> to <b>August 16, 57</b> and last saw <sup>not</sup> him alive on <b>Aug. 15, 57</b> . Death occurred at <b>11 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <b>Erwin C. Calverly M.D.</b>		22b. ADDRESS <b>Weston, Missouri</b>		22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-18-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Ridge Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Weston, Missouri</b>
24. FUNERAL DIRECTOR <b>Vaughn Funeral Home Weston, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Aug 17-19 57</b>	26. REGISTRAR'S SIGNATURE <b>Phila Rollins</b>

(Licensed Embalmer's Statement on Reverse Side)

Public Health Service  
000-56  
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



SEP 9 1957

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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  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *W. R. Vaughn*

Licensed Embalmer No. *40*

P. O. Address *Weston*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.