

pt. Health,  
c., & Welfare  
S. Public  
alth Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43280  
STATE FILE NUMBER

FILED DEC 3- 1957

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 221

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Polk</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nebraska</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>El Dorado Springs, Mo.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>		Length of stay in lb <u>15 hrs.</u>	d. STREET ADDRESS (If outside, give location) <u>501 S. Sumner</u>
		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Ernest F. M. Schmidt</u>			4. DATE OF DEATH Month Day Year <u>11-27-57</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1886</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Willerton Nebraska</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Christian Schmidt</u>	13b. MOTHER'S MAIDEN NAME <u>Maria Beck</u>	14. NAME OF HUSBAND OR WIFE <u>Rosa Theresa Schmidt</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes—give war or dates of service) <u>no none</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Rosa Theresa Schmidt - El Dorado Springs</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metabolic Acidosis</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Diabetes Mellitus</u>	
	DUE TO (c) <u>260X</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Benign Prostatic Hypertrophy with urinary retention</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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20d. INJURY OCCURRED WHILE AT <input 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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>11-22-57</u> to <u>11-27-57</u> and last saw him alive on <u>11-27-57</u> Death occurred at <u>12:42</u> <u>P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Robert R. Meyer M.D.</u>	22b. ADDRESS <u>El Dorado Springs, Mo.</u>	22c. DATE SIGNED <u>11-29-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-1-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cliftonville Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>El Dorado Springs, Mo.</u>
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24. FUNERAL DIRECTOR <u>Arthur G. W. ...</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>11-30-1957</u>	26. REGISTRAR'S SIGNATURE <u>Anna J. Ferry</u>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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(Licensed Embalmer's Statement on Reverse Side)

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 *Max W. Dickering* .....

Licensed Embalmer No. *4696* .....  
P. O. Address *E. Wash. Spg.* .....

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.