

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017672
STATE FILE NUMBER

FILED JUN 6 1958 Registration District No. 83 Primary Registration District No. 5315 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY <u>COOPEY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>COOPEY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SALINE</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>WOOLDRIDGE MO</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR RESIDENCE <u>WOOLDRIDGE MO</u> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>WOOLDRIDGE MO</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>CHARLES GEORGE SCHRADEY</u>			4. DATE OF DEATH Month Day Year <u>MAY 29-1958</u>
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>OCT 13-1867</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	9c. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>90</u> Months Days Hours Min. <u>5</u> <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	10c. BIRTHPLACE (City and state or country) <u>GERMANY</u>
11. BIRTHPLACE (City and state or country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>GERMANY</u>	
13a. FATHER'S NAME <u>HENRY SCHRADEY</u>		13b. MOTHER'S MAIDEN NAME <u>HENRIETTA SEARCH</u>	14. NAME OF HUSBAND OR WIFE <u>ELIZABETH SCHRADEY</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INSURANT Address <u>Carroll Lebowitz</u> <u>Princeton MO</u>
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>Arterio-sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>4500F</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Post operative fractured hip</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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	
21. I attended the deceased from <u>April 1</u> to <u>May 29-58</u> and last saw ^{him} alive on <u>May 25</u> Death occurred at <u>12 Noon</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M. L. DuRuey M.D.</u>		22b. ADDRESS <u>Bronaue K0</u>	22c. DATE SIGNED <u>5/31/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BUTIAL</u>	23b. DATE <u>MAY 31-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT GROVE</u>	23d. LOCATION (City, town, or county) (State): <u>NEAR WOOLDRIDGE MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>G. ALBERT HORNBECK R. R. #111 E HOME MO</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 31-1958</u>	26. REGISTRAR'S SIGNATURE <u>Virginia T. Higgins</u>

(Licensed Embalmer's Statement on Reverse Side)

270
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 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.

JUN 26 1958

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 *to Albert Hornbeck*

Licensed Embalmer No. *2714*

P. O. Address *Prairie Home Mo.*

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.