

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021236

STATE FILE NUMBER

FILED JUN 24 1958

Registration District No.

70

Primary Registration District No.

4124

Registrar's No.

42

300
-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>CLARK</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLARK</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kahoka</u> Inside Limits OR TOWN <u>Kahoka</u> No <input type="checkbox"/>			c. CITY OR TOWN <u>Kahoka 6230</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If in hospital, give location) <u>Wenhohs</u> Length of stay in 1b			d. STREET ADDRESS (If outside, give location) <u>879 W. Cedar</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charley</u> Middle <u>Martin</u> Last <u>Schreck</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>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>MARCH 17, 1880</u>	9. AGE (In years last birthday) <u>78</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Patrick, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Schreck</u>		13b. MOTHER'S MAIDEN NAME <u>Sophia Schnitzer</u>		14. NAME OF HUSBAND OR WIFE <u>Mary J. Schreck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT <u>Mr. Mary J. Schreck Kahoka, Mo.</u> Address		
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>Apoplexy Cerebral</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>334X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <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	
21. I attended the deceased from <u>April 1-58</u> to <u>6/4-58</u> and last saw her alive on <u>6/1-58</u> Death occurred at <u>10-10 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Dr. C. E. Todd D.O.</u>			22b. ADDRESS <u>Williams town Mo.</u>		22c. DATE SIGNED <u>6/6-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JUNE 6, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Patrick Mo.</u>
24. FUNERAL DIRECTOR <u>Otis L. Nuttley Kahoka, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>6/8-58</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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 *John P. Polini*
Licensed Embalmer No. *5035*

P. O. Address *Kahala, 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.