

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010028

STATE FILE NUMBER

FILED MAR 18 1959

Registration District No. 172 Primary Registration District No. 4269 Registrar's No. 22

300
1-57

1. PLACE OF DEATH a. COUNTY <u>LAFAYETTE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>LAFAYETTE</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CORNER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CORNER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>604 E WILSON ST.</u>		Length of stay in 1b <u>69 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>604 E. WILSON ST</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>RUPERT</u> Middle <u>STANLEY</u> Last <u>SCHALLER</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>12</u> Year <u>1959</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>SEPT 6, 1889</u>		9. AGE (In years last birthday) <u>69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COAL MINER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COAL MINES</u>	11. BIRTHPLACE (City and state or country) <u>HIGGINSVILLE, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>RUDOLPH SCHALLER</u>		13b. MOTHER'S MAIDEN NAME <u>LAURA HUMPHRIES</u>		14. NAME OF HUSBAND OR WIFE <u>MILDRED SCHALLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>490-16-4000</u>	17. INFORMANT <u>MILDRED SCHALLER</u> Address <u>CORNER 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>Septicemia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Autolephasia</u> DUE TO (c) <u>General Paralysis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</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.)		
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 _____, to _____ and last saw ^{her} him alive on _____ Death occurred at <u>2</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Denny Parrott Sheriff acting corner</u> (Degree or title) <u>3</u>			22b. ADDRESS <u>Lexington Mo</u>		22c. DATE SIGNED <u>3-13-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/14/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>CORNER, MO.</u>
24. FUNERAL DIRECTOR <u>E. S. Jones</u>		ADDRESS <u>Concordia, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>mar. 16 - 59</u>	26. REGISTRAR'S SIGNATURE <u>Lutee Gordon Jordan</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

doctor, coroner, etc.: must use only standard nomenclature in their report. No symptoms with are listed. All diseases in Part I must be causally related.

MAR 28 1950

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

Student
Signature of Student Embalmer

Signed E. L. James.....

Licensed Embalmer No. 2058.....

P. O. Address Ponca.....

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.