

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019599

STATE FILE NUMBER

Registration No. 4999

FILED JUN 4 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

|  |                           |   |   |
|--|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY _____   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MISSOURIA b. COUNTY FRANKLIN                              |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN ST. LOUIS<br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                           | c. CITY OR TOWN SULLIVAN<br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION MISSOURI-BAPTIST HOSP. 7 WKS<br>Length of stay in lb  |                           | d. STREET ADDRESS (If outside, give location)<br>302 MAPLE ST.<br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>        |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>RUSSELL C. SCHMIDT   |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>MAY 21 1959             |
| 5. SEX<br>MALE   | 6. COLOR OR RACE<br>WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>MARCH 20, 1907                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>MANAGEMENT  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>DELIVERY SERVICE   | 11. BIRTHPLACE (City and state or country)<br>ELMONT, Mo.     |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                           | 13a. FATHER'S NAME<br>CHARLES SCHMIDT   |   |
| 13b. MOTHER'S MAIDEN NAME<br>MAUDE BLANKENSHIP   |                           | 14. NAME OF HUSBAND OR WIFE<br>EDITH SHOUPTS  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>NO   |                           | 16. SOCIAL SECURITY NO.<br>487-38-2219  | 17. INFORMANT<br>EDITH SCHMIDT SULLIVAN, Mo.<br>Address       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of left lung<br>DUE TO (b) Lung<br>DUE TO (c) 163x<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |                           |   | INTERVAL BETWEEN ONSET AND DEATH                              |
| 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<br>Hour Month, Day, Year<br>p.m.   |                           | 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   |   |
| 21. I attended the deceased from April 6-59 to 5-21-59 and last saw her alive on 5-21-59.<br>Death occurred at Mt. Pleasant 20 m on the date stated above; and to the best of my knowledge, from the causes stated.  |                           |   |   |
| 22a. SIGNATURE<br>Edwin J. Pittman, M.D.   |                           | 22b. ADDRESS<br>16 Hampton Valley Plaza   |   |
| 22c. DATE SIGNED<br>5-21-59  |                           |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  | 23b. DATE<br>MAY 24 1959  | 23c. NAME OF CEMETERY OR CREMATORY<br>I.O.O.F. MEMORIAL CEM.  | 23d. LOCATION (City, town, or county) (State)<br>SULLIVAN Mo. |
| 24. FUNERAL DIRECTOR<br>H.M. EATON SULLIVAN, Mo  |                           | 25. DATE RECD. BY LOCAL REG.<br>MAY 23 '59  | 26. REGISTRAR'S SIGNATURE<br>Edwin J. Pittman, M.D.           |

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

696! 7 NOV

DEC 4 1962

VS AUG 26 1960

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 *Harrison M. Eator* .....

Licensed Embalmer No. *4192* .....

P. O. Address *Sullivan, 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.