

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-024019
STATE FILE NUMBER

FILED VS AUG 11 1959

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 76

1. PLACE OF DEATH a. COUNTY <u>aldion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>aldion</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Fairfax mo</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rock-Port mo</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) <u>Fairfax hospital</u>			Length of stay in lb <u>0</u>		d. STREET ADDRESS (If outside, give location) <u>030</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Schooler</u> Last <u>Volkmann</u>				4. DATE OF DEATH Month <u>aug</u> Day <u>2</u> Year <u>1959</u>				
5. SEX <u>7</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15-1893</u>		9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Rock-Port mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>0</u>	
13a. FATHER'S NAME <u>Floyd H. Schooler</u>			13b. MOTHER'S MAIDEN NAME <u>Gda Bell McCarthey</u>			14. NAME OF HUSBAND OR WIFE <u>Otto Volkmann (deceased)</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.		17. INFORMANT <u>Mrs. Ella Roberson</u>		Address <u>Rock-Port 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>Generalized abdominal metastasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 mo</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Primary adenocarcinoma of rectum</u>						<u>10 1/2 mo</u>		
DUE TO (c) _____						<u>154 X</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 _____ Month _____ Day _____ a.m. _____ p.m. _____								
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>Oct-1958</u> to <u>Aug-2-1959</u> and last saw ^{her} him alive on <u>Aug 2-1959</u> Death occurred at <u>3:45 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Ruth Schooler</u>				22b. ADDRESS <u>Rock-Port mo</u>		22c. DATE SIGNED <u>8-3-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Aug-4-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood cemetery</u>		23d. LOCATION (City, town, or county) <u>Rock-Port mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Bestman Funeral Home - Rock-Port mo.</u>			ADDRESS <u>Rock-Port mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 6 1959</u>	26. REGISTRAR'S SIGNATURE <u>Therwin H. Schooler</u>		

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.

443-0

0961

6 APR

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 C. E. Bertram.....
by ms. C. E. Bertram
Licensed Embalmer No. 1724.....

P. O. Address Rockport me.....

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.