

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027936

FILED VS JUL 27 1959

Registration District No. 262 Primary Registration District No. 6235 Registrar's No. 37

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <b>Warren</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Warren</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Pinckney township</b>		Length of stay in 1b <b>1 hour</b>		c. CITY OR TOWN <b>Treloar</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1 mile S.E. of Treloar</b>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Marthasville R.R.3</b>	
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>Henry</b> Last <b>Scharnhorst</b>				4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-21-1901</b>	9. AGE (last birthday) <b>57</b>	IF UNDER 1 YEAR Months <b>57</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>		11. BIRTHPLACE (City and state or country) <b>Warren County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Wm. H. Scharnhorst</b>			13b. MOTHER'S MAIDEN NAME <b>Marie Potthoff</b>		14. NAME OF HUSBAND OR WIFE <b>Cora Hanke Scharnhorst</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>496-38-2358</b>		17. INFORMANT Address <b>R.R.#3</b> <b>Mrs. Roy Scharnhorst, Marthasville, MO</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 <b>the medical care</b> to <b>in Part I &amp; 2</b> and last saw her/him alive on _____ Death occurred at <b>7:30</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>F. H. Kupper D.C. (Coroner)</b>				22b. ADDRESS <b>Warrenton Mo</b>		22c. DATE SIGNED <b>July 20 1959</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-22-59</b>	23c. NAME OF CEMETERY OR REPOSITORY <b>Immanuel's E&amp;R Church</b>		23d. LOCATION (City, town, or county) <b>Holstein, Mo.</b>		
24. FUNERAL DIRECTOR <b>F.W. Nieburg &amp; Co., Warrenton, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>July 21, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Floyd Logan</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 17 1959

FEB 19 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John J. Hieburg

Licensed Embalmer No. 3897

P. O. Address Warrenton,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.