

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028676

FILED VS SEP 8 1959

Registration District No. 118 Primary Registration District No. 5437 Registrar's No. 24

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Gasconade</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bourbois Twp.</u>		Length of stay in lb <u>lifetime</u>		c. CITY OR TOWN <u>Red Bird</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>His home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Bland, Mo. Rt.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>GUSTAV THEODORE SCHEEL</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>29</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>11-22-1897</u>		9. AGE (last birthday) <u>61</u>					
IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone</u>		11. BIRTHPLACE (City and state or country) <u>Red Bird, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Carl Scheel</u>				13b. MOTHER'S MAIDEN NAME <u>Caroline Drusch</u>				14. NAME OF HUSBAND OR WIFE <u>Arvy Sewell Scheel</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>488-42-9127</u>		17. INFORMANT <u>Mrs. Arvy Scheel</u> Address <u>Red Bird, 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>Acute Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>3 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Rheumatoid Arthritis - 20 yrs.</u>								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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>9:30 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Paul Brown, M.D.</u> (Degree or title)						22b. ADDRESS <u>Owensville, Mo.</u>				22c. DATE SIGNED <u>8-31-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>9-1-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bowen Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Red Bird, Mo.</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Gottenstroeter F. Home Owensville, Mo.</u>						25. DATE RECD. BY LOCAL REG. <u>September 1, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Marvin Jappmeyer</u>					
<u>Wilford H H Winter</u> (Licensed Embalmer's Statement on Reverse Side)													

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 8 1959

MAR 31 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 *Me* Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Miguel H H Winter*

Licensed Embalmer No. 383

P. O. Address OWEN SUILLA

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.