

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036394

FILED VS. NOV 10 1959

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5175

RENDERED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Cole</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	Length of stay in 1b <u>7 mos.</u>	c. CITY OR TOWN <u>Lohman</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give name) HOSPITAL OR INSTITUTION <u>Cover Home 100 East 36 St</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural Rfd</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Cynthia M. Scheperle</u>			4. DATE OF DEATH Month Day Year <u>Oct. 27 1959</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>8-26-81</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
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 <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Hickory Hill Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>	
13a. FATHER'S NAME <u>Richard B. Glover</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Short</u>			14. NAME OF HUSBAND OR WIFE <u>John J. Scheperle</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>None</u>		17. INFORMANT Address <u>Mrs. Evelyn Connard K. C. 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>Hypostatic Pneumonia</u> DUE TO (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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 Month, Day, Year 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 May 59 to 10-27-59 and last saw her ^{her} ~~him~~ alive on 10-26-59
 Death occurred at 3 1/2 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James D. Dunleavy MD</u>		22b. ADDRESS <u>314 Wirthman Bldg KC 9 Mo</u>		22c. DATE SIGNED <u>10-27-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>OCT. 29-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springtown</u>	
			23d. LOCATION (City, town, or county) (State) <u>Cole County Mo.</u>		

24. FUNERAL DIRECTOR ADDRESS <u>Wagner Funeral Home K.C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-27-59</u>		26. REGISTRAR'S SIGNATURE <u>Oliver Minshel</u>	
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION
James D. Dunleavy

BY AFFIDAVIT OF

0961 5 JAN SA

0961 7 JAN

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 Alvin R. Hauschild

Licensed Embalmer No. 4159

P. O. Address H. E. 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.