

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-041458**

FILED VS DEC 8 1959

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 149

EMBED

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre</b>		c. CITY OR TOWN <b>French Village</b>	
Length of stay in 1b <del>XXXXXX</del>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bonne Terre Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>*****</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) * <b>J O H N J O S E P H S A C H M I D</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>25,</b> Year <b>1959</b>	
First Middle Last				

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-7-1957</b>	9. AGE (last birthday) <b>2</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of <del>working</del> life, even if retired) <b>NONE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>***</b>	11. BIRTHPLACE (City and state or country) <b>Bonne Terre, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Leon J. Schmidt</b>	13b. MOTHER'S MAIDEN NAME <b>Eula Moore</b>	14. NAME OF HUSBAND OR WIFE <b>*****</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>*****</b>	17. INFORMANT <b>Leon &amp; Eula Schmidt</b>	Address <b>French Village</b>
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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>Laryngeal diphtheria</b>		INTERVAL BETWEEN ONSET AND DEATH
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) <b>Interstitial pneumonia.</b>	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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 _____
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21. I attended the deceased from **Have never attended** and last saw **him** alive on **Did not see**.  
Death occurred at **7:30 P. M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title)	22b. ADDRESS <b>Bonne Terre, Missouri</b>	22c. DATE SIGNED <b>11/28/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-28-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Ann's Catholic</b>	23d. LOCATION (City, town, or county) (State) <b>French Village, Mo.</b>
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24. FUNERAL DIRECTOR <b>C &amp; Z Boyer &amp; Son Inc. Bonne Terre Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Nov. 28, 1959</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MULLEN

**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 B. T. Boyer  
B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address Desloge, 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.