

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 8 1961

-60-045491

STATE FILE NUMBER

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 1

IDED

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clinton</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cameron</u>		Length of stay in 1b <u>22 yrs.</u>		c. CITY OR TOWN <u>Cameron</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>Home 108 Evergreen</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>108 Evergreen St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>/HENRY</u> Last <u>SCHLORFF</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</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>7-6-1884</u>		9. AGE (last birthday) <u>76</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>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>			11. BIRTHPLACE (City and state or country) <u>Clinton, Co. Mo.</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13a. FATHER'S NAME <u>Fred Schlorff</u>				13b. MOTHER'S MAIDEN NAME <u>Emma Blocher</u>				14. NAME OF HUSBAND OR WIFE <u>Effie Schlorff</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 <u>Effie Schlorff, Cameron, Mo.</u> Address							
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>Congestive Heart failure</u>										INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Myocardial Inefficiency.</u>										<u>10 yrs</u>			
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Recent Acute Virus Influenza.</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 <u>12-17-60</u> to <u>12-28-60</u> and last saw her ^{her} him alive on <u>12-28-60</u> Death occurred at <u>3:20 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>[Signature]</u> (Degree or title)						22b. ADDRESS <u>D.O. Cameron, Mo.</u>			22c. DATE SIGNED <u>12-28-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 30, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Graceland</u>			23d. LOCATION (City, town, or county) (State) <u>Cameron, Mo.</u>						
24. FUNERAL DIRECTOR <u>Poland Funeral Home, Cameron, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>1-1-61</u>		26. REGISTRAR'S SIGNATURE <u>Francis D Crawford</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert F. Colson

Licensed Embalmer No. 427
927 West
P. O. Address Camden

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