

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000266

FILED VS JAN 9 1961

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 5120 Registrar's No. 4

AMENDED

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in 1b <b>7 Years</b>	c. CITY OR TOWN <b>Columbia</b> 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>Lenoir Memorial Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Lenoir Memorial Home</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>B.</b> Last <b>SCHEITLIN</b>			4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>1961</b>	
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-23-1866</b>	9. AGE (last birthday) <b>94</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 working life, even if retired) <b>Contractor</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	11. BIRTHPLACE (City and state or country) <b>Galesburg, Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>unknown</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Elizabeth Cameron</b>
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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.	17. INFORMANT <b>Lenoir Memorial Home, Columbia, Mo.</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>Bronchial pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</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
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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.)
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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 **Oct 1956** to **Jan 61** and last saw <sup>her</sup>him alive on **31 Dec 60**  
Death occurred at **1:30 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>LeRoy J Miller MD</b> (Degree or title)	22b. ADDRESS <b>Sutler Bldg Columbia, Mo</b>	22c. DATE SIGNED <b>Jan 61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-3-61</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>State Anatomical Board</b>	23d. LOCATION (City, town, or county) <b>Columbia, Missouri</b>
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24. FUNERAL DIRECTOR <b>Parker Funeral Service, Columbia, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Jan 3 1961</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DATE AMENDED  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

DATE OF DEATH STV

**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, <sup>Not</sup>  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed JW Phillips  
Licensed Embalmer No. 4897  
P. O. Address Columbus Ms

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.