

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026105

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 247 Primary Registration District No. 5840 Registrar's No. 19

FILED AUG 11 1961

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| 1. PLACE OF DEATH a. COUNTY NEWTON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY JASPER | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN VAN BUREN TWP. | | Length of stay in 1b 17 MOS. | c. CITY OR TOWN SARCOXIE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4 M. E. OF DIAMOND | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 711 JOPLIN ST. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First DELLA Middle F. Last SCHROLL | | | 4. DATE OF DEATH Month AUG. Day 6, Year 1961 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10-2-1874 | 9. AGE (last birthday) 86 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY HOMEMAKING | 11. BIRTHPLACE (City and state or country) ILLINOIS | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME SOLOMON OSBORN | | 13b. MOTHER'S MAIDEN NAME SARAH BAILEY | 14. NAME OF HUSBAND OR WIFE CHARLES BAILEY SCHROLL |

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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) NO | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT MRS. CLIFFORD WILEY, SARCOXIE, MO. |
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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) <i>Cardio-vascular disease & heart failure 10 yrs</i> DUE TO (b) <i>Arteriosclerosis, generalized 10 yrs</i> DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Diabetes mellitus</i> | | 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 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 _____ | | |

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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 2-25-61 to 8-6-61 and last saw her 8-5-61 alive on _____
Death occurred at 8:05 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>M. Foster Miller</i> (Degree or title) | 22b. ADDRESS M.D. 616 W. CENTENNIAL, CARTHAGE | 22c. DATE SIGNED 8-8-61 |
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|--|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 8-8-1961 | 23c. NAME OF CEMETERY OR CREMATORY SARCOXIE, MO. | 23d. LOCATION (City, town, or county) SARCOXIE, MO. (State) |
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| 24. FUNERAL DIRECTOR ULMER-MOSS FUNERAL HOME, SARCOXIE, MO. | ADDRESS | 25. DATE RECD. BY LOCAL REG. Aug. 9, 1961 | 26. REGISTRAR'S SIGNATURE <i>M. L. Young</i> |
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Melvin C. Savell

Licensed Embalmer No. 5121

P. O. Address CARTHAGE, 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.