

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**61-028384**  
STATE FILE NUMBER

AMENDED

Filed District No. **38**

Primary Registration District No. **5120**

Registrar's No. **549**

**FILED SEP 11 1961**

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Boone</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Columbia</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>Boone</b>	
Length of stay in 1b <b>12 Days</b>		c. CITY OR TOWN <b>Rocheport</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>-----</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Boone Co. Rest Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX	
First <b>ROSA</b>			Middle <b>SCHIPPERT</b>			Last <b>September 1, 1961</b>	
6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-18-1892</b>		9. AGE (last birthday) <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Harlan Co., Nebraska</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Schippert</b>			13b. MOTHER'S MAIDEN NAME <b>Johanna Bauerle</b>			14. NAME OF HUSBAND OR WIFE <b>-----</b>	
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. <b>-</b>		17. INFORMANT <b>Walter Schippert, Route 1, Rocheport,</b>		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							MO. INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>							<b>3 days</b>
DUE TO (b) <b>Cerebral Thrombosis</b>							<b>5 days</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
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 <b>August 21, 61</b> to <b>Sept 1, 1961</b> and last saw her alive on <b>Aug 29, 1961</b> Death occurred at <b>1:00</b> P m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>B. A. Maramba, II, M.D.</b>				22b. ADDRESS <b>1504 East Broadway</b>		22c. DATE SIGNED <b>9/2/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9-4-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Alma Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Alma, Nebraska</b>		
24. FUNERAL DIRECTOR <b>Parker Funeral Service, Columbia, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>Sept 4 1961</b>		26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>		

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

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 by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Donald L Roberts

Licensed Embalmer No. 4722  
P. O. Address Columbia 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.