

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001238

Dr. Auner

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 134

STATE FILE NUMBER

AMENDED

FILED JAN 29 1962

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 6 DAYS	c. CITY OR TOWN OZARK
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MERCY HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last GERALD L. SCHREINER	4. DATE OF DEATH Month Day Year JAN. 22 1962
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/26/12	9. AGE (last birthday) 49	IF UNDER 1 YEAR Months Days	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) MEAT CUTTER	10b. KIND OF BUSINESS OR INDUSTRY HIGHLANDVILLE MEAT PLANT	11. BIRTHPLACE (City and state or country) KEOKUK, IOWA	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME GEORGE WASHINGTON SCHREINER	13b. MOTHER'S MAIDEN NAME ELSIE FRYE	14. NAME OF HUSBAND OR WIFE NONCLIS SCHREINER
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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.	17. INFORMANT Address NONCLIS SCHREINER, OZARK, 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) <u>Postoperative Anemia + Clipping of</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Aneurysms of Aorta of W. this</u> DUE TO (c) <u>Previous rupture of Subarachnoid Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>6 weeks</u>
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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.	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 <u>October 1961</u> to <u>1-22-62</u> and last saw him live on <u>1-20-62</u> Death occurred at <u>2:35 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Cliff Auner MD</u>	22b. ADDRESS <u>600 S. Glenstone Springfield, Mo</u>	22c. DATE SIGNED <u>1-23-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 1/23/62	23c. NAME OF CEMETERY OR CREMATORY SOUTH ENGLISH, IOWA	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 1-25-62	26. REGISTRAR'S SIGNATURE <u>Effie J. Meltzer</u>
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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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 *V. H. McCarver*

Licensed Embalmer No. 2727

P. O. Address *Spalding*

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.