

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-014394

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 110

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 7 1962	
1. PLACE OF DEATH a. COUNTY <u>Callaway</u>	
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>	Length of stay in 1b <u>22½</u> years
c. CITY OR TOWN <u>Palmyra</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>	
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 <u>Roxy Schimmelberger</u>	
4. DATE OF DEATH Month Day Year <u>April 28 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1894 ?</u>
9. AGE (last birthday) <u>67</u>	
IF UNDER 1 YEAR Months Days Hours Min.	
IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	
11. BIRTHPLACE (City and state or country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>unk</u>	
13b. MOTHER'S MAIDEN NAME <u>unk</u>	
14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>	
16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT Address <u>State Hospital No. 1, Fulton, Mo.</u>	
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>adenocarcinoma of stomach with metastasis</u>	
INTERVAL BETWEEN ONSET AND DEATH	
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	
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	
<u>State Hospital No. 1 7-15-1939 to 4-28-1962</u>	
21. He attended the deceased from _____ and resided with him on _____ Death occurred at <u>7:00 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22. SIGNATURE (Degree or title) <u>James K. Pitterhusch M.D.</u>	
22b. ADDRESS <u>Fulton, Missouri</u>	
22c. DATE SIGNED <u>4/30/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>5-1-62</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	
23d. LOCATION (City, town, or county) (State) <u>Columbia Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Rt. 2, P.O. Johnston Columbia Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>May 1 - 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

10147

20640

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USE BLACK INK OR TYPEWRITER RIBBON

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.