

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-031664
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 70 Primary Registration District No. 5274 Registrar's No. 40

FILED AUG 27 1963

VS 300
Rev. 4/59

1 0230
2 0230
3
4 1
5 0
6
7 1
8 1
9 X
10
11 023
12 91-3
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBON

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Clark</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clark</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>S. of Wayland, Mo.</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Francisville, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Highway # 61</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Maire Schorr</u>			4. DATE OF DEATH Month Day Year <u>Aug. 1, 1963</u>
5. SEX <u>Female</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>Dec. 5, 1961</u>
9. AGE (last birthday) <u>1 yr 8 Mos.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Keokuk, Iowa</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Charles Schorr</u>	13b. MOTHER'S MAIDEN NAME <u>Carol Lalanda</u>
14. NAME OF HUSBAND OR WIFE <u>Never Married</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Charles Schorr, St. Francisville, 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>Crushed Brain</u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> DUE TO (b) <u>Extensively crushed skull</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>automobile accident</u>	
20c. TIME OF INJURY Hour <u>9.30</u> p.m. Month, Day, Year <u>8-1-63</u>	20d. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) <u>Highway 61</u>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>Clark</u>	COUNTY <u>MO</u>	STATE
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>SA Shannon D. Coroner</u>		22b. ADDRESS <u>Kahoka Mo</u>	22c. DATE SIGNED <u>8-8-63</u>
23a. BURIAL, CREMATION, REPOUSE (Specify) <u>Burial</u>	23b. DATE <u>Aug. 4, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sand Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Francisville, Missouri</u>
24. FUNERAL DIRECTOR'S ADDRESS <u>Karl Shaffer, Kahoka, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Aug-12-1963</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MAR 11 1964

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 *W. Schaffer*

Licensed Embalmer No. 5063

P. O. Address *Shake, 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.