

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012769

STATE FILE NUMBER

FILED APR 28 1959 Registration District No. 83 Primary Registration District No. 5514 Registrar's No. 5

300
1-57

1. PLACE OF DEATH a. COUNTY <u>COOPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>COOPER</u>	
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) <u>PRAXIE HOME</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>PRAXIE HOME MO.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>PRAXIE HOME MO.</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>PRAXIE HOME MO</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM EDWIN SCHNUR</u>			4. DATE OF DEATH Month Day Year <u>APR 16 22 1959</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 9 - 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	9. AGE (In years last birthday) <u>66</u> 10. FUNDING YEAR Months Days Hours Min. <u>9 11</u>
11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13a. FATHER'S NAME <u>WILLIAM SCHNUR</u>		13b. MOTHER'S MAIDEN NAME <u>HELENE SCHWAM</u>	
14. NAME OF HUSBAND OR WIFE <u>LIZZIE (DEAD)</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. <u>489-16-2851</u>		17. INFORMANT Address <u>Mrs A. L. Gaff Prairie Home</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>Coronary Thrombosis</u> 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) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instentaneous</u>
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 Month, Day, Year 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	
21. I attended the deceased from <u>July 1954</u> to <u>April 22, 1959</u> and last saw him alive on <u>April 8, 1959</u> Death occurred at <u>9:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Louise M. Geelagher M.D.</u>		22b. ADDRESS <u>California, Mo.</u>	
22c. DATE SIGNED <u>4/23/59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <u>APRIL 24-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MONTEAU EURN.</u>	
23d. LOCATION (City, town, or county) <u>NEAR PRAXIE HOME MO</u>		23e. STATE <u>MO.</u>	
24. FUNERAL DIRECTOR <u>C. ALBERT HO-N-BECK</u> <u>PRAXIE HOME MO.</u>		25. DATE RECD. BY LOCAL REG. <u>4/24/59</u>	
26. REGISTRAR'S SIGNATURE <u>Virginia T. Higgins</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *to Albert Hornbeck*

Licensed Embalmer No. *2714*

P. O. Address *Bairns Home*

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.