

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-032674

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 224 Primary Registration District No. 4333 Registrar's No. 50

FILED SEP 14 1965

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Moniteau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Moniteau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clarksburg, Mo</u>		c. CITY OR TOWN <u>Clarksburg, Mo</u>	
Length of stay in 1b <u>4 Yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home-- Gen Del</u>		d. STREET ADDRESS (If outside, give location) <u>Gen Del</u>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>Joseph</u> Last <u>Scholl</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>1965</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/88</u>
9. AGE (last birthday) <u>77</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (City and state or country) <u>Cooper Co</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph Scholl</u>		13b. MOTHER'S MAIDEN NAME <u>Betty Scott</u>	
14. NAME OF HUSBAND OR WIFE <u>Mabel Scholl</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>489-42-6769</u>		17. INFORMANT Address <u>Mrs Mabel Scholl-Clarksburg, 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>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Progressive Cerebral Thrombosis</u> DUE TO (c) <u>Arteriosclerosis</u> 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 type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>9-7-65 only</u> and last saw him alive on <u>9-7-65</u> Death occurred at <u>11/10A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>California, Mo</u>	
22c. DATE SIGNED <u>9-11-65</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>10/12/65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tipton Oddfellow Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Tipton, Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>Bowlin Funeral Home-California, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-12-65</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

SEP 16 1965

SEP 14 1965

APR 7 1965

# 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

*Jack H. Fowler*

Licensed Embalmer No. 4933

P. O. Address California, 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.