THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000344
STATE FILE NUMBER

FEB 9 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 141

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY OR TOWN: St. Joseph — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 807 South 15th — Length of stay in 1b: Life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Buchanan
c. CITY OR TOWN: St. Joseph — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 307 South 15th — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: LEO Middle: J. Last: SCHOTT SR.

4. DATE OF DEATH: Month Day Year: Feb. 3, 1959

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	WIDOWED [X]	Feb. 14, 1881	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
Tavern Owner	Tavern	St. Joseph, Mo.	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
William Schott	Anna Kneib	Josephine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	500-36-1079A	Henry Schott	807 So. 15th St. Joseph, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 Mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): ASHD. (Arteriosclerotic heart disease) — 3 Yrs.
DUE TO (c): SENILITY

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4 200 — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] — 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 [ ] NOT WHILE AT WORK [ ] — 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 11/7/58 to 2/2/59 and last saw him alive on 2/2/59
Death occurred at 7:45 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert Rogers M.D. — 22b. ADDRESS: 307 Kirkpatrick Bldg St Jo Mo — 22c. DATE SIGNED: 2/3/59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	Feb. 6, 1959	Mt. Olivet Cemetery	St. Joseph, Mo.

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Sidenfaden Funeral Home St Joseph, Mo. (Licensed Embalmer's Statement on Reverse Side)	Feb 5, 1959	Mrs. Clark Tindell

NO Sidenfaden Jr Son RR 4

All diseases in Part I must be causally related.

Dr. John F. Rogers

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Rogers

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 Robert H. Kapp

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.