

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25260**
Registrar's No. **6615**

BIRTH NO. #53601 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.0		d. STREET ADDRESS (If rural, give location) 2402 No. Grand	
3. NAME OF DECEASED (Type or Print) a. (First) HENRY b. (Middle) SCHMIDT c. (Last)			4. DATE OF DEATH (Month) June (Day) 27th (Year) 1949
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) unknown	8. DATE OF BIRTH Aug. 26th 1867
9. AGE (In years, Months, Days)		10. KIND OF BUSINESS OR INDUSTRY Restuarant	11. BIRTHPLACE (State or foreign country) Unknown Mo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dishwasher		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Frank Schmidt		13b. MOTHER'S MAIDEN NAME Anna Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME M. Renard		ADDRESS St. Louis City Hospital	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease & Failure		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma Colon & Liver Metastases			

19a. DATE OF OPERATION 6-22-49	19b. MAJOR FINDINGS OF OPERATION Carcinoma of colon & liver metastases		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 462	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 15.3 X	

22. I hereby certify that I attended the deceased from **2/6/49**, 19___, to **6/21/49**, 19___, that I last saw the deceased alive on **6/21/49**, 19___, and that death occurred at **5:25 PM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Albert Repoff, M.D.		23b. ADDRESS 1515 Lafayette Ave.	23c. DATE SIGNED 7/8/49
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE JUL 31 1949	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. JUL 31 1949	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL HOME'S SIGNATURE Rowland Mortuary Service ADDRESS 4104 Manchester Ave.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD



U.S. 1934

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
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 this body is not embalmed, fact should be so stated above.