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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 2 1949

State File No. 25534

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 1801

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN <b>RICHMOND HEIGHTS</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>HADDE CITY</b>	
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) <b>CLAYTON and LINDBERG RP. 1</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. MARY'S HOSPITAL</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>JULY 3-1949</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>ADEL</b> b. (Middle) <b>SCHULTE</b> c. (Last) _____		5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>		8. DATE OF BIRTH <b>JUNE 13-1888</b>	
9. AGE (In years last birthday) <b>61</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <b>ST. LOUIS, MO</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>DAVID SCHULTE</b>		13b. MOTHER'S MAIDEN NAME <b>MARY ROBBIN</b>	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Mary Muckerman Lindberg</b> ADDRESS <b>Clayton and Lindberg Rd.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>Carcinoma of breast</b>		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS <b>170X</b>	
ANTECEDENT CAUSES <b>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>		DUE TO (b) <b>Carcinoma of breast</b>	
DUE TO (c) _____		III. OTHER SIGNIFICANT CONDITIONS _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from Oct 1946, to July 2, 1949, that I last saw the deceased alive on July 2, 1949, and that death occurred at 4 a.m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <b>Paul Kramer M.D.</b>		23b. ADDRESS <b>6947 Deane</b>	
23c. DATE SIGNED <b>7-3-49</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
24b. DATE <b>JULY 5-1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEM.</b>	
24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, MO</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>H. Mullen and Co.</b> ADDRESS <b>5165 DELMAR BL</b>	
DATE REC'D BY LOCAL REG. <b>7-7-49</b>		REGISTRAR'S SIGNATURE <b>Walter R. Mendenhall</b>	

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

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**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.

Signed *H. J. Harris*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3284

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.