

FILED MAY 10 1950

STANDARD CERTIFICATE OF DEATH

14974

State File No. _____

318

1003

3895

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE INDIANA b. COUNTY Knox	
b. CITY OR TOWN ST. LOUIS	c. LENGTH OF STAY (in this place) 12 days	c. CITY OR TOWN VINCENNES	8130
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 917 HART	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) JOHN	b. (Middle) BAPTIST	c. (Last) SCHMIDT	APRIL	27,	1950

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 4 1892	9. AGE (In years) 57	# UNDER 1 YEAR Months	# UNDER 24 HRS. Days	# UNDER 1 MIN. Hours	# UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator	10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Belgium	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME August Schmidt	13b. MOTHER'S MAIDEN NAME Maria Mossant	14. NAME OF HUSBAND OR WIFE Martha Schmidt
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Nil	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Martha Schmidt Vincennes, Indiana
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 15 min.
This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Hodgkin disease	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.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) 2011
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from April 14 19 50, to April 27 19 50, that I last saw the deceased alive on April 27, 19 50, and that death occurred at 8:25 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Mary Jane Gray MD	23b. ADDRESS Barnes Hospital	23c. DATE SIGNED 4/27
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-28-50	24c. NAME OF CEMETERY OR CREMATORY City	24d. LOCATION (City, town, or county) (State) Vincennes, Indiana
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DATE REC'D BY LOCAL REG. APR 28 1950	REGISTRAR'S SIGNATURE J. B. Laster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed

Alvin R. Powell

Licensed Embalmer No. 077

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.