

FILED MAR 8 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6611

State File No. _____

1581

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri.</u> b. COUNTY <u>St. Louis.</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Normandy</u> <u>4171</u>	
c. LENGTH OF STAY (in this place)		d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Lukes Hospital.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) <u>9600 Natural Bridge Rd.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>WILFRED</u>	b. (Middle)	c. (Last) <u>SCHADE.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feby 16, 1951.</u>
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5. SEX <u>Male.</u>	6. COLOR OR RACE <u>White.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed.</u>	8. DATE OF BIRTH <u>March 5, 1870.</u>	9. AGE (In years last birthday) <u>80.</u>	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custom House Broker (Retired).</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>(Unknown) Schade.</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown.</u>	14. NAME OF HUSBAND OR WIFE <u>Harriet Schade.</u>
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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) <u>no.</u>	16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Carlisle Schade</u>	ADDRESS <u>9600 Natural Bridge</u>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broncho pneumonia.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Bronchiectasis</u> DUE TO (c) <u>Emphysema, Chronic Bronchitis</u>		
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)
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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? <u>502.0</u>
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22. I hereby certify that I attended the deceased from 2-15, 1951, to 2-16, 1951, that I last saw the deceased alive on 2-16, 1951, and that death occurred at 4:10 Am., from the causes and on the date stated above.

23a. SIGNATURE <u>Michael M. Karl</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>3720 Washington Blvd.</u>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation.</u>	24b. DATE <u>2/16/51.</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>	24d. LOCATION (City, town, or county) (State) <u>7800 St. Charles Road.</u>
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DATE REC'D BY LOCAL REG. <u>FEB 16 1951</u>	REGISTRAR'S SIGNATURE <u>J. B. Foster</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C. R. Lupton & Sons</u>	ADDRESS <u>7233 Delmar Bly'd</u>
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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.....

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.