

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43312

FILED JAN 16 1952

State File No. 11809

318

1003

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 <u>Mo</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis Mo</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>5400 Arsenal Street St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS STATE HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED a. (First) <u>MARY</u> b. (Middle) <u>SCHLUETER</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 28 1951</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>abt 1876</u>		9. AGE (In years last birthday) <u>75</u>	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) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Mo 10</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>Link</u>		13b. MOTHER'S MAIDEN NAME <u>Link</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Record</u> ADDRESS _____			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs x</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility</u>  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 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? <u>H2O</u>					
22. I hereby certify that I attended the deceased from <u>May 1, 1945</u> to <u>Dec. 28, 1951</u> , that I last saw the deceased alive on <u>Dec. 28, 1951</u> , and that death occurred at <u>1:55 P.M.</u> , from the causes and on the date stated above.							
23. SIGNATURE <u>John Schlenker, M.D.</u> (Degree or title) _____				23b. ADDRESS <u>5400 Arsenal Street</u>		23c. DATE SIGNED <u>12/31/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>JAN 10 1952</u>		24c. NAME OF FUNERAL HOME OR UNDERTAKER <u>Anatomical Board</u>		24d. LOCATION (City, town, or county) (State) _____	
DATE REC'D BY LOCAL REG. <u>10 1952</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland Mortuary Service</u> ADDRESS <u>4104 Manchester Ave</u>			

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

try from family

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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.

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.