

STANDARD CERTIFICATE OF DEATH

11148

State File No.

FILED MAR 29 1952
191773

BIRTH NO. 191773 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 553

1. PLACE OF DEATH a. COUNTY St. Louis		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 Richmond Heights		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis <u>2129</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS (If rural, give location) 5201 Cabanne Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Stephen b. (Middle) c. (Last) Schatz			4. DATE OF DEATH (Month) (Day) (Year) Feb. 27, 1952		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Feb. 1, 1952	9. AGE (In years last birthday) 26	10. KIND OF BUSINESS OR INDUSTRY
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			11. BIRTHPLACE (State or foreign country) Richmond Heights, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME James Schatz	13b. MOTHER'S MAIDEN NAME Ruth Guthrie	14. NAME OF HUSBAND OR WIFE None
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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. None	17. INFORMANT'S SIGNATURE OR NAME James Schatz	ADDRESS 5201 Cabanne Ave.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory failure		INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 week 1 week
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) E. Coli meningitis		
	DUE TO (c) Colostomy		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Imperforate anus			!!

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 7561	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?
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22. I hereby certify that I attended the deceased from Feb 1, 1952 to Feb 7, 1952, that I last saw the deceased alive on Feb 27, 1952 and that death occurred at 1:30 p. m., from the causes and on the date stated above.

23a. SIGNATURE LeRoy Hughes	(Degree or title)	23b. ADDRESS 3284 Ivanhoe	23c. DATE SIGNED 2-27-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-28-52	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Sullivan, Mo.
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DATE REC'D BY LOCAL REG. 2-28-52	REGISTRAR'S SIGNATURE Herbert R. Donke MD	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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SW (Licensed Embalmer's Statement on Reverse Side)

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

S. No. 300
V. 10-48

4005

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.....

John J. Staines

Signed.....

Student Embalmer

Licensed Embalmer No. *4408*

P. O. Address. *St. Louis Mo.*

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.