

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14749**
Registrar's No. **3721**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY 1			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY 2019		
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6607 Minnesota Ave.			d. STREET ADDRESS (If rural, give location) 1 6607 Minnesota Ave.		
3. NAME OF DECEASED a. (First) ALBERT		b. (Middle)		c. (Last) SCHATZ	
4. DATE OF DEATH (Month) (Day) (Year) April 19 '52.					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 12, 1889	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired since 1919		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Belleville, Ill.	
12. CITIZEN OF WHAT COUNTRY?					
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Ruth Cleland Schatz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ruth Cleland Schatz 6607 Minnesota	
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, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Endocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Gas Poisoning (War) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Dementia Parcox.			INTERVAL BETWEEN ONSET AND DEATH 87-90 327-90 327-90.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None.			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 421.4	
22. I hereby certify that I attended the deceased from Sept. 1, 1948 to April 19, 1952 , that I last saw the deceased alive on April 18, 1952 , and that death occurred at 12:00 a.m. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Dr. Rev. W. Amb M.D.		23b. ADDRESS 1504 S. Howard.		23c. DATE SIGNED 4/19/52.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Apr. 21, 1952		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.					
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 21 1952		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.	

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

m/B (Licensed Embalmer's Statement on Reverse Side)

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 *Edwin M. Aermatt*

Licensed Embalmer No. *3024*

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.