

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12292**
Registrar's No. **3228**

FILED APR 4 1953

BIRTH NO. 860109 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

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 town) <u>St. Louis</u>		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>University City</u> <u>4376</u>		d. STREET ADDRESS (If rural, give location) <u>875 Berick Drive</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Saint Louis Maternity</u>						
3. NAME OF DECEASED (Type or Print) a. (First) <u>Schuchat</u> b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>March 15 1953</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>March 10 1953</u>		9. AGE (In years last birthday) if UNDER 1 YEAR Months Days if UNDER 24 HRS. Hours Min. <u>5 16 10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Stanley Ries Schuchat</u>		13b. MOTHER'S MAIDEN NAME <u>Rosalind Cook</u>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. --	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Stanley & Rosalind Schuchat 875 Berick Dr.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Prematurity, incompatible with life 24 weeks</u> 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. <u>Atelectasia</u>			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>7625</u>			
22. I hereby certify that I attended the deceased from <u>March 10</u> , 19 <u>53</u> , to <u>March 15</u> , 19 <u>53</u> that I last saw the deceased alive on <u>March 15</u> , 19 <u>53</u> , and that death occurred at <u>2:20 Pm.</u> , from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) <u>Meriam M. Pennoyer MD</u>			23b. ADDRESS <u>St. Louis Maternity Hosp</u>		23c. DATE SIGNED <u>3-15-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>3-31-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>MAR 26 1953</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rowland 4104 Manchester</u>		

(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 _____

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.