

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12655

542 State File No.

FILED MAR 20 1953

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 543 Registrar's No. 704

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			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>Ferguson</u>		c. LENGTH OF STAY (In this place) <u>8 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Ferguson</u>		4119
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>126 S. Florissant Rd.</u>			d. STREET ADDRESS (If rural, give location) <u>120 S. Florissant Rd.</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>Allie</u> b. (Middle) <u>Virginia</u> c. (Last) <u>Schmidt</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>3--2--1953</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>7--27--1866</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 100 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Pittsfield, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Dr. Chas. W. Rivers</u>	13b. MOTHER'S MAIDEN NAME <u>Emoline Widdow</u>	14. NAME OF HUSBAND OR WIFE <u>Edward H. Schmidt</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>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Dr. C. R. Schmidt, Ferguson, Mo</u>	ADDRESS _____
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral apoplexy</u>	DUE TO (b) <u>arterio-sclerosis</u>		<u>3 days</u>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	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"/>
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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) _____	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 2/26, 1953, to 3/2, 1953, that I last saw the deceased alive on 3/1, 1953, and that death occurred at 11 A.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J.C. Kuebrich M.D.</u>	23b. ADDRESS <u>9 S. Florissant Rd, Ferguson Mo</u>	23c. DATE SIGNED <u>3/3/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>3-4-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo</u>
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DATE REC'D BY LOCAL REG. <u>3-3-53</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Dombrowski</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>White Chapel</u>	ADDRESS <u>Ferguson, Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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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 Eleanore Poince

Licensed Embalmer No. 3403

P. O. Address Jennings Ma

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.