

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16497

State File No. \_\_\_\_\_

FILED APR 29 1953

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>545</u>		Registrar's No. <u>1120</u>	
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 _____			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Maplewood, Mo.</u>		c. LENGTH OF STAY (in this place) <u>5 Mos.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		<u>2059</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hanley Nursing Home</u>				d. STREET ADDRESS (If rural, give location) <u>6249 Northwood Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mr. A.</u>		b. (Middle) <u>CHARLES</u>		c. (Last) <u>SCHMID</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 17, 1953</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>December 5, 1871</u>		9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Equitable Life Ins. Co.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Frank L. Schmid</u>			13b. MOTHER'S MAIDEN NAME <u>Louise Woerner</u>			14. NAME OF HUSBAND OR WIFE <u>Adele Louise Schmid</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>490-36-4411</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Dr. T. S. Zahorsky</u>		ADDRESS <u>15 Arundel Place</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* (a) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  <u>331X</u>				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?			
22. I hereby certify that I attended the deceased from <u>Jan 16, 1953</u> to <u>4/17</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>4/17</u> , 19 <u>53</u> , and that death occurred at <u>10:00 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Thomas W. Parker M.D.</u>			23b. ADDRESS <u>4660 Maryland</u>			23c. DATE SIGNED <u>4/18/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>April 20, 53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>	
DATE REC'D BY LOCAL REG. <u>4-18-53</u>		REGISTRAR'S SIGNATURE <u>Hubert R. Donohue-M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Alexander &amp; Sons, Inc. 6175 Delmar Blvd.</u>			

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

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Dr Birdsell or Dr. Parker  
4660 Maryland  
Ro. 6074  
Saturday

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 jos. e McCulloh

Licensed Embalmer No. 2460

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.