

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33405**
8008

FILED OCT 1 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		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 St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pine Lawn 4 157	
c. LENGTH OF STAY (In this place) 3 hrs		d. STREET ADDRESS (If rural, give location) 3744 Salome Ave	
d. FULL NAME OF HOSPITAL OR INSTITUTION S. Lukes Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Ida b. (Middle) D. c. (Last) Hinrichs			4. DATE OF DEATH (Month) (Day) (Year) August 15 1953		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH December 12 1873		9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo
11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo			12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME Edwards Schaberg		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE August F. Hinrichs	
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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS August F. Hinrichs 3744 Salome Ave	

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) _____		ANTECEDENT CAUSES Coronary Thrombosis			
*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 (b) _____			
		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 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) 420.1	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT <input type="checkbox"/> WORK		21f. HOW DID INJURY OCCUR	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **5:35** p.m., from the causes and on the date stated above.

23a. SIGNATURE Calvin F. Fultz		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 8.17.53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE August 19 1953		24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	
				24d. LOCATION (City, town, or county) (State) St. Louis Co Mo	

DATE REC'D BY LOCAL REG. AUG 17 1953		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Calvin F Fultz 4828 Nat Bridge Blvd	
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(Licensed Embalmers' Statement on Reverse Side)

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

No. 300
10.48

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 Ralph C. Zinders

Licensed Embalmer No. 4575

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.