

FILED OCT 30 1953

STANDARD CERTIFICATE OF DEATH

State File No. 37563

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10057

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		e. STREET ADDRESS (If rural, give location) 915 Dover Pl.		2019	
3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) B. c. (Last) SCHMIDT			4. DATE OF DEATH (Month) (Day) (Year) Oct. 20 1953		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widower	8. DATE OF BIRTH Nov. 26, 1881	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker (Retired) First Nat'l. Bank		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	
13a. FATHER'S NAME Charles Schmidt		13b. MOTHER'S MAIDEN NAME Mina Henneke		14. NAME OF HUSBAND OR WIFE Late Anna M. Schmidt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marion E. Schmidt 915 Dover Pl.	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) atherosclerosis  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic myocarditis			INTERVAL BETWEEN ONSET AND DEATH 1 mo  10 years  3 years
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)	
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? 331X	
22. I hereby certify that I attended the deceased from Dec 1948 to Oct 20, 1953, that I last saw the deceased alive on Oct 20, 1953 and that death occurred at 2:00P m., from the causes and on the date stated above.					
23a. SIGNATURE Burchard W. Smith M.D.		23b. ADDRESS 6006 Virginia Ave		23c. DATE SIGNED 10/21/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct. 23, 1953		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	
				24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
DATE REC'D BY LOCAL REG. OCT 21 1953		REGISTRAR'S SIGNATURE Carl Schmidt M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.	

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.....  
Signature of Student Embalmer

Signed *Richard W. Storvick*.....

Licensed Embalmer No...400...

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.