

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41124

FILED NOV 19 1953

State File No. 10422

318

1003

Registrar's No. 10422

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10422	
1. PLACE OF DEATH a. COUNTY _____				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 township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>3 days</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Baptist Hospital</u>				STREET ADDRESS (If rural, give location) <u>5039 Minerva Avenue</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Goldie</u> b. (Middle) <u>M.</u> c. (Last) <u>Schroeder</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11 - 1 - 1953</u>				
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8 - 24 - 1887</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	
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 <u>At home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>New Burnside, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>John Grant</u>		13b. MOTHER'S MAIDEN NAME <u>Lydia Ritter</u>		14. NAME OF HUSBAND OR WIFE <u>John M. Schroeder</u>			
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. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. John N. Schroeder, 5039va Ave.</u> ADDRESS <u>Minerva Ave.</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, asphyxia, 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 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>cerebral arteriosclerosis</u> DUE TO (c) <u>none</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>myocardial infarct</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2</u> <u>year</u> <u>2 year</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>331X</u>			
22. I hereby certify that I attended the deceased from <u>Nov 1, 1952</u> , to <u>Nov 1, 1952</u> , that I last saw the deceased alive on <u>Nov 1, 1952</u> , and that death occurred at <u>2:15 AM.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>M. K. ...</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>3409 Union</u>		23c. DATE SIGNED <u>11-2-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>11/4/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hiram Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>		
DATE REC'D BY LOCAL REG. <u>NOV 3 1953</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Drehmann-Harral</u> ADDRESS <u>1905 Union Blvd.</u>			

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

Dr. Kimelman  
3409 Union Blvd.

1 - 5PM

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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 *Warren A. Carver*.....  
Licensed Embalmer No. *353*

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.