

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 17 1953

State File No. **44465**  
Registrar's No. **11724**

|  |  |   |  |  |  |   |   |  |
|--|--|---|--|--|--|---|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <b>318</b>   |  | PRIMARY REG. DIST. NO. <b>1003</b>   |  | Registrar's No. _____   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Illinois,</b> b. COUNTY <b>Alexander</b> |  |   |   |  |
| b. CITY (If outside corporate limits, write RURAL and give town or township)<br><b>ST. LOUIS, MISSOURI</b>   |  | c. LENGTH OF STAY (In this place) _____   |  | c. CITY OR TOWN <b>Cairo.</b>  |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Barnes Hospital</b>   |  |   |  | e. STREET ADDRESS (If rural, give location) <b>7th Street.</b>   |  |   |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Darrel</b>  |  | b. (Middle) <b>Smith</b>  |  | c. (Last) <b>Schuh</b>   |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>December 9 1953</b>   |   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>  |  | 8. DATE OF BIRTH <b>Apr. 20, 1894.</b>  |   |  |
| 9. AGE (In years last birthday) <b>59.</b>   |  | IF UNDER 1 YEAR Months _____ Days _____   |  | IF UNDER 4 HRS. Hours _____ Min. _____   |  |   |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Drug Store Operator.</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store.</b> |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Cairo, Illinois.</b> |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13a. FATHER'S NAME <b>P.H. Schuh</b>   |  |   | 13b. MOTHER'S MAIDEN NAME <b>Amelia Smith</b>        |  |  | 14. NAME OF HUSBAND OR WIFE <b>Amanda Schuh.</b>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>   |  | 16. SOCIAL SECURITY NO. <b>W.W. 1 355-28-1779</b>   |  | 17. INFORMANT'S SIGNATURE OR NAME <b>Amanda Schuh, Cairo, Illinois.</b>  |  |   |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Leiomyosarcoma of the jejunum with metastases to the liver</b><br>ANTECEDENT CAUSES<br><b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br><b>Conditions contributing to the death but not related to the disease or condition causing death.</b> |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Over 2 yrs.</b>                              |  |
| 19a. DATE OF OPERATION _____   |  | 19b. MAJOR FINDINGS OF OPERATION _____  |  |  |  |   | 20. AUTOPSY?<br>YES <input checked="" 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? <b>152X</b>   |  |   |   |  |
| 22. I hereby certify that I attended the deceased from <b>11-22-</b> , 19 <b>53</b> , to <b>12-9-</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>12-9-</b> , 19 <b>53</b> , and that death occurred at <b>11:10p m.</b> , from the causes and on the date stated above. |  |   |  |  |  |   |   |  |
| 23a. SIGNATURE <b>FR Brady</b> (Degree or title) <b>M.D.</b>   |  |   |  | 23b. ADDRESS <b>BARNES HOSPITAL</b>  |  | 23c. DATE SIGNED <b>12-10-53</b>  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>   |  | 24b. DATE <b>12-10-53</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Villa Ridge Cemetery</b>   |  | 24d. LOCATION (City, town, or county) (State) <b>Villa Ridge, Illinois.</b>   |   |  |
| DATE REC'D BY LOCAL REG. <b>DEC 11 1953</b>  |  | REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington.</b>  |  |   |   |  |

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.....

Licensed Embalmer No. *4199*

P. O. Address *St. Louis*

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.