

Health, Welfare and Public Service
 300 1-56
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All standard nomenclature in item 18. No symptoms will be listed. All standard nomenclature in item 18. No symptoms will be listed. All standard nomenclature in item 18.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED SEP 6 1956

318

1003

29107
 STATE FILE NUMBER
 7039

Registration District No. Primary Registration District No. 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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis	
c. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1		Length of stay in lb 4 yrs	
		13 STREET ADDRESS Chronic Hospital	

3. NAME OF DECEASED (Type or print) CLARA SCHUCK (Schuk)		4. DATE OF DEATH Month Day Year JULY 27, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20-1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis Mo.
13. FATHER'S NAME Herman Bergmann		14. MOTHER'S MAIDEN NAME Catherine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		17. INFORMANT Address Emily Gallager 4206 San Francisco	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 3 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) arteriosclerotic heart disease		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	420.0	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 8/4/56 to 7/27/56 and last saw her alive on 7/27/56 Death occurred at 7:20 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) Leroy F. Cartwright M.D.	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 7/30/56

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 31-1956	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR ADDRESS Leidner Undertaking Co 2223 St. Louis Av		25. DATE RECD. BY LOCAL REG. JUL 30 1956	26. REGISTRAR'S SIGNATURE Carl Smith MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *J W M Benkle*

Licensed Embalmer No. *36*

P. O. Address *St Paul*

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.

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