

FILED DEC 20 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

43835

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10564**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN 4000 BELLEFONTAINE NEIGHBORS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DE PAUL HOSPITAL		d. STREET ADDRESS (If outside, give location) 1213 Jennings Station Rd.	
3. NAME OF DECEASED (Type or print) First WALTER Middle L. Last SCHROETER		4. DATE OF DEATH Month Nov. Day 18, Year 1956.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1896.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-CLERK		10b. KIND OF BUSINESS OR INDUSTRY BANK	9. AGE (In years last birthday) 60
11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD C. SCHROETER		14. MOTHER'S MAIDEN NAME IDA EHLHARDT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WORLD WAR #1.		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. GOLDIE SCHROETER, 1213 Jennings Sta. Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of skull and Brain; Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) E976X			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Gully inflicted in house on		
20c. TIME OF INJURY Hour 12:35 Month 11 Day 18 Year 1956 p. m. 12:35 p.m.	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION Bellefontaine Neighbors		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 220 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James M. Reay (Deputy)		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 11-19-56			
23a. BURIAL, CREMATION, REINTERMENT (Specify)	23b. DATE 11/21/56	23c. NAME OF CEMETERY OR CREMATORY BELLEFONTAINE CEMETERY	23d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.
24. FUNERAL DIRECTOR CALVIN F. FEUTZ FUNERAL HOME, INC. 4828 Natural Bridge Blvd. St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. NOV 19 1956	26. REGISTRAR'S SIGNATURE Paul Smith MD m83

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Royce L. Linder

Licensed Embalmer No...4

P. O. Address...*St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.