

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3065**
Registrar's No. **608**

FILED FEB 4 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

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) 28 yrs.	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 01 5057 Durant Ave.		4. STREET ADDRESS (If rural, give location) 5057 Durant Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) J. c. (Last) Schmalzried		4. DATE OF DEATH (Month) (Day) (Year) 1 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 19, 1876
9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 10 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stagehand		10b. KIND OF BUSINESS OR INDUSTRY Theatre	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME William Schmalzried	
13b. MOTHER'S MAIDEN NAME Katherine		14. NAME OF HUSBAND OR WIFE unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 492-05-6896	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Wm. J. Schmalzried 5057 Durant
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 1952	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 420.0	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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?	
22. I hereby certify that I attended the deceased from 1952 , 19___, to Jan. 19, 1957 , that I last saw the deceased alive on Dec. 19, 1956 , and that death occurred at 10:30 p. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Haklin M.D.		23b. ADDRESS 5074 N. Union	23c. DATE SIGNED 1-21-57
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 1/23/57	24c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
DATE REC'D BY LOCAL REG. JAN 21 '57	REGISTRAR'S SIGNATURE Carl Smith MA	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral 1905 Union	

Dr. Harry A. Klein
5074 Union Blvd.
Ev. 5-1030

Hrs. 10:30 - 5

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.