

FILED APR 29 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15251

STATE FILE NUMBER  
1003 3212

Registration District No. 318 Primary Registration District No. 1003 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 St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN St. Louis Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Ferguson 4109 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If outside, give location) 27 226 Henquin Dr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in lb 09 2 hrs			

3. NAME OF DECEASED (Type or print) First MIDDLE Last JESSIE R. SCHMITZ			4. DATE OF DEATH Month Day Year April 1, 1957		
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 Nov. 13, 1884	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		100. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Benton Co., Arkansas		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
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. 499-28-5400	17. INFORMANT Address Mrs. Chester Ryals, 226 Henquin Dr.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease 15 yrs. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 hrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post operative nail in left hip on 7-16-1955			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2		
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.) 420.0				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		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 Oct 1953 to April 1957 and last saw her alive on 4/1/57. Death occurred at 5 pm on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Walter S. Wilson, M.D.			22b. ADDRESS 40 N Florence and Ferguson		22c. DATE SIGNED 4/2/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-3-57	23c. NAME OF CEMETERY OR CREMATORY Frieden's Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri	
24. FUNERAL DIRECTOR ADDRESS WHITE CHAPEL, FERGUSON, MISSOURI		25. DATE RECD. BY LOCAL REG. APR 3 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Health Service  
S. 300  
1-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms need be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
securing the medical certification in the appropriate manner required by 195.140, March 1947.

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 *Eleanor Province*

Licensed Embalmer No. 3403

P. O. Address Jennings, M

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.