

Health, Welfare Public Service

300 1-56 3

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUN 5 1957

THE DIVISION OF PUBLIC HEALTH
STANDARD CERTIFICATE OF DEATH

166578

STATE FILE NUMBER

Registration District No. 113 Primary Registration District No. 5430 Registrar's No. 620

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If not usual residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Central</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) <u>666 Hiway - 2 mi E. Clair</u>			Length of stay in lb HOSPITAL OR INSTITUTION <u>200</u>	d. STREET ADDRESS <input checked="" type="checkbox"/> (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Glady's E Schroeder</u>				4. DATE OF DEATH <u>6-1-57</u>		Month <u>6</u> Day <u>1</u> Year <u>57</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-10-1902</u>		9. AGE (In years last birthday) <u>54</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work - Ft-House</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Ft-House</u>		11. BIRTHPLACE (City, state, or country) <u>Ind -</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar Durine</u>				14. MOTHER'S MAIDEN NAME <u>Hettie Morrison</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		(If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Harry Schroeder</u> Address <u>St. Louis Mo</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DISEASE WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE FRACTURES OF RIB CASE,</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>FRACTURE RT HIB, FRACTURE LEFT PULVER</u> DUE TO (c) <u>MULTIPLE CONTUSIONS</u> — DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>INSTANTANEOUS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Auto Accident</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" 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.) <u>Auto Accident - Two Car</u>					
20c. TIME OF INJURY Hour <u>2:30</u> Month <u>6</u> Day <u>1</u> Year <u>57</u> P. M. <u></u>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>1.5 mi East St Clair on Hw. 66 Franklin Mo</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>		COUNTY <u>Franklin</u>		STATE <u>MO</u>		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>St. Louis Mo</u>		22c. DATE SIGNED <u>6/1/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>6-4-'57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo</u>			
24. FUNERAL DIRECTOR <u>Shenwood W Kitchell</u> ADDRESS <u>St. Clair, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>6-2-57</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

(Licensed Embalmer's Statement on Reverse Side)

511-1

1931 2 2 MIP

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..... *Sherwood W. Mitchell*

Licensed Embalmer No. *38*

P. O. Address *St. Clair*

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.