

300
1-56

Health, Welfare & Public Service
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 JUL 26 1957

STANDARD CERTIFICATE OF DEATH

26542

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6307**

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Length of stay in lb 22^{1/2} STREET ADDRESS 4828 Allemania (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Theodore Middle H Last Schoendienst		4. DATE OF DEATH Month July Day 5 Year 1957	
5. SEX male	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 Feb 14, 1864
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY shipping clerk	9. AGE (In years last birthday) 93
11. BIRTHPLACE (City and state or country) Germentown, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Schoendienst		14. MOTHER'S MAIDEN NAME not known	
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. none	
17. INFORMANT Paul Schoendienst		Address 4828 Allemania	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Right Hip; DUPLICATE (b) Generalized Arterio Sclerosis; DUPLICATE (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) Suffered in fall at			INTERVAL BETWEEN ONSET AND DEATH
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.) Slipped and fell at 8:49 Gravois on July 1, 1957		
20c. TIME OF INJURY Hour 8:49 a. m. p. m. 7 Month 7 Day 1 Year 57	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> EA 04.7 45		
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, etc.) Nursing Home	20f. CITY, TOWN, OR LOCATION St. Louis	COUNTY Mo STATE 000
21. I attended the deceased from 7:00 P. to 7:00 P. and last saw her/him alive on 7/8/57			
22a. SIGNATURE Patrick B. Taylor Casper (Degree & title)		22b. ADDRESS 300 Clark	22c. DATE SIGNED 7/8/57
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 7/8/1957	23c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cem	23d. LOCATION (City, town, or county) St. Louis, Mo. (State)
24. FUNERAL DIRECTOR J L Ziegenhein & Sons ADDRESS 7027 Gravois		25. DATE RECD. BY LOCAL REG. JUL 8 57	26. REGISTRAR'S SIGNATURE Karl Smith MD

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 *Donald E. Benz*

Licensed Embalmer No. *78*

P. O. Address *7075*

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.