

Health
Welfare
Public
Service

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I-56

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27082

FILED AUG 5 1957

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1855

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: 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>Gardenville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Affton 4830</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Henninger Nursing Home</u> Length of stay in 1b		d. STREET ADDRESS <u>10048 Baptist Church Rd.</u> (If outside, give location) Reside on Farm No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louisa</u> Middle <u>F</u> Last <u>Schmidt</u>			4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1957</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 29, 1877</u>
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Columbia, Ill.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Fred Meyer</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Koch</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mildred Godin 10048 Baptist Ch. Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Uremia</u> DUE TO (b) <u>Arteriosclerotic kidneys & gen. arteriosclerosis</u> DUE TO (c) <u>Extrem. hot weather</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 days</u> <u>?</u> <u>?</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			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.)			20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a. m. <u> </u> p. m. <u> </u>
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 <u>2:50</u> <u>6/25/57</u> to <u>7/25/57</u> and last saw her alive on <u>7/24/57</u> Death occurred at <u> </u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W.F. Neuman M.D.</u> (Degree or title)		22b. ADDRESS <u>5-203 Chippewa</u>	22c. DATE SIGNED <u>7/25/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>7/27/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Churchyard</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>J L Ziegenhein & Sons 7027 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>7-26-57</u>	26. REGISTRAR'S SIGNATURE <u>Hebeek R. Amick M.D.</u>

(Licensed Embolmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

