

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29984

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7562**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		a. STATE Missouri b. COUNTY St. Louis ✓	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Memorial Home		c. CITY OR TOWN St. Louis	
Length of stay in 1b 6 yrs.		STREET (If outside, give location) 2609 So. Grand	
3. NAME OF DECEASED (Type or print) Albert		4. DATE OF DEATH Month 8 Day 11 Year 57	
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 10/28/1863	
9. AGE (In years last birthday) 93		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Madnesskeeper		10b. KIND OF BUSINESS OR INDUSTRY City of St. Louis	
11. BIRTHPLACE (City and state or country) Alton Ill.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Charles W. Scheutzel		14. MOTHER'S MAIDEN NAME Philipina Meyer	
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 Harold E. Scheutzel		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebral arteriosclerosis DUE TO (c) 33 1/2			INTERVAL BETWEEN ONSET AND DEATH 1 day 37 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			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.)
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 Jan 1 1957 to Aug 11 1957 and last saw him alive on Aug 9 1957 Death occurred at 3 p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE B. Todd Ferguson M.D.		22b. ADDRESS 3720 Washington St. Linn 8	22c. DATE SIGNED 13 Aug 57
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 8/14/57	23c. NAME OF CEMETERY OR CREMATORY St. Paul Church yard	23d. LOCATION (City, town, or county) (State) St. Louis county Mo.
24. FUNERAL DIRECTOR Schumachers funeral home Inc.		25. DATE RECD. BY LOCAL REG. AUG 13 57	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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 by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Jack Haupt*.....

Licensed Embalmer No. *4*.....

P. O. Address *St. Paul*.....

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.