

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29995

XC # 830 88 09
 SL # 13779 FILED AUG 26 1957

STATE FILE NUMBER 7504

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	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS. A. DM. HOSP.		Length of stay in lb 72 DAYS	d. STREET ADDRESS (If outside, give location) 2234 2632A LEMP Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RUEBEN Middle S Last SCHUELKE			4. DATE OF DEATH Month 8 Day 8 Year 57
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-18
9. AGE (In years last birthday) 38	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHEF		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) GARFIELD, MINNESOTA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CARL SCHUELKE	
14. MOTHER'S MAIDEN NAME Hermína Brueske		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II	
16. SOCIAL SECURITY NO. 473-18-8202		17. INFORMANT Address VA HOSPITAL RECORDS, ST. LOUIS, MISSOURI	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MONOCYTTIC LEUKEMIA, GENERALIZED			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			204.2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EDEMA			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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	20g. COUNTY
20h. STATE			
21. I attended the deceased from 5-28-57 to 8-8-57 and last saw her him alive on 8-8-57 Death occurred at 9:25 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Herbert Lule</i> (Degree or title) M. D.		22b. ADDRESS VAH, ST. LOUIS, MISSOURI	22c. DATE SIGNED 8-9-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-12-1957	23c. NAME OF CEMETERY OR CREMATORY St. John's Cem.	23d. LOCATION (City, town, or county) (State) Garfield, Minnesota
24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette		25. DATE REC'D. BY LOCAL REG. AUG 12 57	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> S.P.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *H. Y. Farrow*.....

Licensed Embalmer No. *3*

P. O. Address *H. Y. Farrow*.....

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.