

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38108
STATE FILE NUMBER
9251

FILED OCT 21 1957

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		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 3961^a Lafayette Ave			Length of stay in lb 53 yrs	d. STREET ADDRESS (If outside, give location) 2179^b 3961a Lafayette Ave			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print): CLARA Louise SCHMIDT				4. DATE OF DEATH Month Oct. Day 2, Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 30, 1876		9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Washington, Mo.		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Frank Schmidt			13b. MOTHER'S MAIDEN NAME Anna Mary Meyer		14. NAME OF HUSBAND OR WIFE none		
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. 494-07-6044	17. INFORMANT Address Theodore Schmidt, 9120 Vassel, Affton, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH sudden	
DUE TO (b) <input checked="" type="checkbox"/> Hypertension							
DUE TO (c) _____						331x	
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"/>	
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 <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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 5/22/56 to 5/9/57 and last saw her alive on 5/9/57 Death occurred at 8:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE John H. Diemer M.D. (Degree or title)				22b. ADDRESS 1504 S. Grand St. Louis 4, Mo.		22c. DATE SIGNED 10/3/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE Oct. 7, 1957	23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave			25. DATE RECD. BY LOCAL REG. OCT 4 57		26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. M. J. B.		

(Licensed Embalmer's Statement on Reverse Side)

USE ONE-INK-BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. John Duemler
1504 S. Grand Ave.
111 5 PM

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 David Samuel

Licensed Embalmer No. 4520

P. O. Address St Louis mo

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.