

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38780

STATE FILE NUMBER

FILED NOV 15 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2610

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Frontenac</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Frontenac</u> <u>4000</u> <u>0</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Conway Rd. Box 430</u>				Length of stay in lb <u>4 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>Conway Rd. Box 430</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BERTHA</u>			First <u>IRENE</u>		Middle <u>SCHOELCH</u>		Last		
4. DATE OF DEATH <u>October 20, 1957</u>			Month		Day		Year		
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>Feb. 26, 1890</u>		9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
						Months <u>7</u>	Days <u>24</u>	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Ferdinand Maul</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Blanke</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Wesley C. Schoelch</u>		Address <u>Conway 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>Cerebral hemorrhage</u>								INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Cerebral arteriosclerosis</u>		DUE TO (c) <u>331X</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</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 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 <u>Nov 4, 1957</u> to <u>Oct. 20, '57</u> and last saw her <u>her</u> alive on <u>10/20/57</u> Death occurred at <u>9:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>James J. [Signature]</u>				(Degree or title) <u>M.D.</u>		22b. ADDRESS <u>35 N. Central</u>		22c. DATE SIGNED <u>10/21/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Oct. 23, '57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>			
24. FUNERAL DIRECTOR <u>Ambruster Mortuary, 6633 Clayton Rd.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-22-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Donche M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

use

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health & Welfare Public Service
300
1-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
If the medical certification in this specific manner required by 125.140 R.S.Mo. 1957.

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.....
Tracy L. Lamm

Licensed Embalmer No. *4780*

P. O. Address *St. Louis*

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.