

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42585
State File No.

FILED DEC 9 - 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10871**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS		c. CITY OR TOWN FLORISSANT	
c. LENGTH OF STAY (in this place) 3 WEEKS		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION DE PAUL HOSPITAL		e. STREET ADDRESS (If rural, give location) R. R. #1, Box #55 (PARKER RD.)	
3. NAME OF DECEASED (Type or Print) a. (First) DOROTHY b. (Middle) SOPHIA c. (Last) SCHNETT GOECKE		4. DATE OF DEATH (Month) (Day) (Year) NOVEMBER 11, 1957	
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 1, 1919
9. AGE (In years last birthday) 38		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME CHARLES G. SCHROEDER	
13b. MOTHER'S MAIDEN NAME AMELIA ELSTERMEYER		14. NAME OF HUSBAND OR WIFE WILLIAM SCHNETT GOECKE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME WILLIAM SCHNETT GOECKE		ADDRESS FLORISSANT, MO.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION Toxic myocarditis Toxic Myocarditis Enterocolitis Enterocolitis 586x	
19a. DATE OF OPERATION 10-28-57		19b. MAJOR FINDINGS OF OPERATION Post operative Cholecystectomy Cholecystectomy	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 days 2 wks	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-24 , 19 57 , to 11-11 , 19 57 , that I last saw the deceased alive on 11-11 , 19 57 , and that death occurred at 11 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE H.O. Schreppel		23b. ADDRESS 634 No. Grand, St. Louis, Mo 634 No. Grand	
23c. DATE SIGNED 11-14-57		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE NOV. 15, 1957		24c. NAME OF CEMETERY OR CREMATORY CALVARY	
24d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI		25. FUNERAL DIRECTOR'S SIGNATURE Gene A. Whitehead	
DATE REC'D BY LOCAL REG. NOV 14 57		ADDRESS FLORISSANT, MO.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Gene A. Hutchins*
Licensed Embalmer No. *4966*

P. O. Address *Houston, Tex.*

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.