

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 6 1958

3566
STATE FILE NUMBER
873
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

300
1-57

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 5802 1/2 WABADA-AV.	Length of stay in lb 40 YRS.	d. STREET ADDRESS 5802 1/2 WABADA-AV.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN SCHRAUTEMEIER			4. DATE OF DEATH Month Day Year JAN. 23RD 1958	
5. SEX FEMALE	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 FEB. 8TH 1913	9. AGE (In years last birthday) 44 YRS. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) LYONS - KANSAS	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME JOHN-SULLIVAN		13b. MOTHER'S MAIDEN NAME ALVINA-FREDERICH S		14. NAME OF HUSBAND OR WIFE FRANK-L-SCHRAUTEMEIER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 487-18-0644	17. INFORMANT Address FRANK L. SCHRAUTEMEIER - 5802 1/2 WABADA-AV.	

18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure			INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Pulmonary Metastasis		4 months
	DUE TO (c) Cystadenoma of Ovaries		18 months
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.) 175.0
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
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21. I attended the deceased from Nov. 1957 to 1-23-58 and last saw her alive on 1-22-58
Death occurred at 7:30 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James M. Fleiter, M. D.	22b. ADDRESS 97270 Natural Bridge Rd.	22c. DATE SIGNED 1-24-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JAN. 25TH 1958	23c. NAME OF CEMETERY OR CREMATORY CALVARY-CEMETERY	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
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24. FUNERAL DIRECTOR Brockland Und. Co. 1827-HOGAN-ST	ADDRESS	25. DATE RECD. BY LOCAL REG. JAN 24 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.
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(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

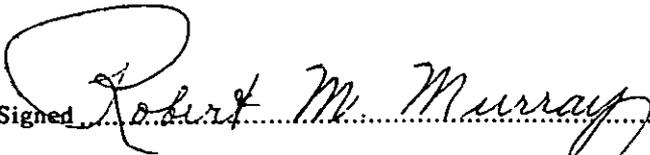
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Part 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 

Licensed Embalmer No. 3749
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.