

FILED JAN 30 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3573

STATE FILE NUMBER

687

Registration District No. 318

318

Primary Registration District No. 1003

1003

Registrar's No.

300

1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>		Length of stay in 1b	4. STREET ADDRESS (If outside, give location) <b>6142 Kingsbury Place</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>August</b> Middle <b>B.</b> Last <b>Schulze</b>			4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>February 21, 1869</b>		9. AGE (In years last birthday) <b>88</b> 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) <b>Retired Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>	11. BIRTHPLACE (City and state or country) <b>Okawville, Illinois.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Herman Schulze</b>		13b. MOTHER'S MAIDEN NAME <b>Susan Tscharne</b>		14. NAME OF HUSBAND OR WIFE <b>Unavailable</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Luville Lamb, 6142 Kingsbury Place.,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of the Right Hip.</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>E903.020</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" 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.) <b>Slipped while cleaning steps and fell at his home at 6142 Kingsbury on January 16 1958. Right tibia fractured.</b>				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <b>1 16 58</b>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION, COUNTY, STATE <b>St. Louis Mo.</b>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>129 A.D. Popple</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>James M. Kelly</b> (Degree or title) <b>Physician</b>		22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>1-20-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>1-21-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 20 '58</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b> mfs	

**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 ..... *W. W. Wilkinson*

Licensed Embalmer No. *3575*  
P. O. Address *A. 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.