

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034672

STATE FILE NUMBER 8377

FILED SEP 29 1958

6945528 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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 ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN OVERLAND 4000	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DE PAUL HOSPITAL		d. STREET ADDRESS 3554 NORMAN AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last INFANT (GIRL) SCHMIDT		4. DATE OF DEATH Month Day Year Aug 28, 1958	
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 Aug 28, 1958
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Edward O. Schmidt		13b. MOTHER'S MAIDEN NAME Katherine Truska	
14. NAME OF HUSBAND OR WIFE XXXXXXXXXXXX		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Edw. O. Schmidt 3554 Norman Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranial Hemorrhage DUE TO (b) Hydrocephalus. DUE TO (c) 752x 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 2 hrs. 2 hrs.
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 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 Birth to AUG 28-58 and last saw her alive on AUG 28-1958 Death occurred at 8:35 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. J. Howell (degree or title)		22b. ADDRESS 8700 Riverview Blvd.	
22c. DATE SIGNED 8-29-58		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 8/29/58		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
23d. LOCATION (City, town, or county) (Street) St. Louis, Missouri		24. FUNERAL DIRECTOR JOHN STYGAR & SON - 5541 RIVERVIEW BLVD.	
25. DATE RECD. BY LOCAL REG. AUG 29 58		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

8902 Received
Dr. Korsch

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 *Not Embalmed [Signature]*

Licensed Embalmer No.

P. O. Address

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.