

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037370  
STATE FILE NUMBER

FILED OCT 22 1958 Registration District No. 276 Primary Registration District No. 5945 Registrar's No. 58

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Phelps</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Phelps</b>                     |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>Dillon Township</b>  |                                  | c. CITY OR TOWN <b>Dillon Township</b>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Airport Cafe</b>  |                                  | d. STREET ADDRESS (If outside, give location)<br><b>Airport Cafe</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Eugene</b> Middle <b>Schmittel</b> Last <b>Schmittel</b>   |                                  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>15</b> Year <b>1958</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>October 28, 1893</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cashier</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Cafe</b>  | 9. AGE (In years last birthday) <b>64</b><br>IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/><br>IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Missouri</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13a. FATHER'S NAME<br><b>Henry Schmittel</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Pauline Sertier</b>   |   |
| 14. NAME OF HUSBAND OR WIFE<br><b>Ellen, dec.</b>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                     |   |
| 16. SOCIAL SECURITY NO.<br><b>489-28-4323</b>   |                                  | 17. INFORMANT<br><b>Roy Schmittel</b> Address <b>Warrenton, Mo.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>  |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>0</b>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |                                  |   | <b>4201</b>   |
| 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?<br>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<br>Hour _____<br>a.m. _____<br>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<br><b>St. Louis</b>  |                                  | COUNTY <b>St. Louis</b> STATE <b>Mo.</b>  |   |
| 21. I attended the deceased from _____ to _____ and last saw her alive on _____<br>Death occurred at <b>1 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>Ruth B. Powell Registrar</b>   |                                  | 22b. ADDRESS<br><b>St. James mo</b>   |   |
| 22c. DATE SIGNED<br><b>10-15-1958</b>   |                                  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |                                  | 23b. DATE<br><b>Oct. 17, 1958</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakewood Park Cem.</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Mo.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Null &amp; Sons Funeral Home</b><br>By <b>Paul E. Null</b> ADDRESS <b>Rolla, Mo.</b>   |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>10-15-1958</b>   |   |
| 26. REGISTRAR'S SIGNATURE<br><b>Ruth B. Powell</b>  |                                  |   |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 ..... *Paul E. Null*

Licensed Embalmer No. .... *4498*

P. O. Address ..... *Rolla, 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.