

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038183
STATE FILE NUMBER
9860

FILED OCT 23 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

S. 300
v. 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 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 type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital | | | Length of stay in 1b 20 25 | | d. STREET ADDRESS (If outside, give location) 5639 Goethe Ave | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First DANIEL Middle CONRAD Last SATTEL | | | | 4. DATE OF DEATH Month 10 Day 12 Year 1958 | | | | | | | | | |
| 5. SEX Male | | 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 7-9-1902 | | 9. AGE (In years last birthday) 56 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) St. Louis Mo | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13a. FATHER'S NAME Max Schmatzler | | | | 13b. MOTHER'S MAIDEN NAME Maria Welker | | | | 14. NAME OF HUSBAND OR WIFE Adeliade Sattel | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Adeliade Sattel Address 5639 Goethe 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) Pulmonary Edema DUE TO (b) Acute Cardiac Failure DUE TO (c) Hypertensive Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Ruptured Esophageal Varices due to Hepatic Cirrhosis. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 hr. 5 yrs. | | | |
| 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.) 443x | | | | | | | | | |
| 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 1948 to 10-12-58 and last saw him alive on 10-12-58 Death occurred at 10:25 P. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE H.O. Schrapel, M.D. (Degree or title) | | | | | | 22b. ADDRESS 634 No Grand, St. Louis, Mo | | | 22c. DATE SIGNED 10-14-58 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 10-16-1958 | | 23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery | | | 23d. LOCATION (City, town, or county) (State) 4260 Bates St Mo | | | | | |
| 24. FUNERAL DIRECTOR Jeegenheim Bros ADDRESS 6409 Gravois Ave | | | | | | 25. DATE RECD. BY LOCAL REG. OCT 15 '58 | | 26. REGISTRAR'S SIGNATURE Carl Smith M.D. | | | | | |

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 *Van M. Sigerson*

Licensed Embalmer No. *4343*
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.