

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038511
STATE FILE NUMBER

FILED OCT 20 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 260

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-57

1. PLACE OF DEATH a. COUNTY St. Louis		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 Bonhomme Township		c. CITY OR TOWN Mehlville 4000	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Clayton Rd.		d. STREET (If outside, give location) ADDRESS Hwy-21 Box 2220-Rt#8	
3. NAME OF DECEASED (Type or print) KATHERINE SCHULZ		4. DATE OF DEATH Oct. 11, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1865
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None At home	9. AGE (In years last birthday) 93
11. BIRTHPLACE (City and state or country) St. Louis Co., Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME George Reiss		13b. MOTHER'S MAIDEN NAME Katherine Stock	14. NAME OF HUSBAND OR WIFE Jacob Schulz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Eleanora Fette-Rt#13-St. Louis 22, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 4 2/3 Years 1 1/2
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic Heart Disease 4200H			
DUE TO (c) Carcinoma of Breast with Metastasis			
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.)	
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
21. I attended the deceased from May 2, 1945 to Oct 11, 1958 and last saw her alive on 10-3-58 Death occurred at 7:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Herbert B. Donkely MD		22b. ADDRESS 204 E. Big Bend	22c. DATE SIGNED 10-13-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 14, 1958	23c. NAME OF CEMETERY OR CREMATORY Edm Lawn Cemetery	23d. LOCATION (City, town, or country) (State) St. Louis County 24, Mo.
24. FUNERAL DIRECTOR ADDRESS Pfzinger Mort-Kirkwood 22, Mo.		25. DATE RECD. BY LOCAL REG. 10-14-58	26. REGISTRAR'S SIGNATURE Herbert B. Donkely

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Signature of informant must be carefully retained.

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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 *[Handwritten Signature]*

Licensed Embalmer No. *1366*

P. O. Address *[Handwritten 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.