

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042218

STATE FILE NUMBER

FILED NOV 20 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10793

|  |                           |   |  |   |   |
|--|---------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |                           |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Missouri<br>b. COUNTY |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN<br>St. Louis  |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN<br>St. Louis   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br>0/ 3438 Koekuk St.   |                           | Length of stay in 1b  | d. STREET ADDRESS (If outside, give location)<br>#1690 3438 Koekuk St.,  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Kate Schott  |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>November 10, 1958  |   |   |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>January 3, 1876  | 9. AGE (In years last birthday)<br>82                               | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>at home  | 11. BIRTHPLACE (City and state or country)<br>St. Louis, Missouri  |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |
| 13a. FATHER'S NAME<br>Jacob Berberich  |                           | 13b. MOTHER'S MAIDEN NAME<br>Margaret Rheinhardt  |  | 14. NAME OF HUSBAND OR WIFE<br>Jacob Schott (deceased)              |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No  |                           | 16. SOCIAL SECURITY NO.<br>None   | 17. INFORMANT Address<br>Eleanor Schott 3438 Koekuk St. St. Louis  |   |   |
| 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) Ac. Cardiac dilatation<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) Chr. Myocarditis<br>DUE TO (c) Gen. Arteriosclerosis |                           |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br>4 5 mins.   |
| 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 Month, Day, Year<br>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 10/1/57 to 11/10/58 and last saw her alive on 11/10/58<br>Death occurred at 7:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.  |                           |   |  |   |   |
| 22a. SIGNATURE<br>W.F. Heun  |                           | (Degree or title)   | 22b. ADDRESS<br>5203 Chippewa St., St. Louis 9, Mo.  |   | 22c. DATE SIGNED  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal   | 23b. DATE<br>11-12-1958   | 23c. NAME OF CEMETERY OR CREMATORY<br>Valhalla Mausoleum  |  | 23d. LOCATION (City, town, or county) (State)<br>St. Louis Missouri |   |
| 24. FUNERAL DIRECTOR<br>HOFFMEISTER COLONIAL ADDRESS<br>6464 CHIPPEWA STREET ST. LOUIS, MISSOURI   |                           | 25. DATE RECD. BY LOCAL REG.<br>NOV 10 1958   |  | 26. REGISTRAR'S SIGNATURE<br>J. Earl Smith, M.D.<br>M.J.B.          |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Bill C. Branson* .....

Licensed Embalmer No. *4768* .....

P. O. Address... *St. Louis, 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.