

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046270

STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 316 Primary Registration District No. 1003 Registrar's No. 12340

300
7-57
Patient's name signed by Dr. J. Meswinney. Signed in his name OK by Mr Taylor
All diseases in Part 21 must be usually stated
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

| | | | | | |
|--|---------------------------|---|--|--|---|
| 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 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Ferguson 4109 | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital | | Length of stay in lb 4 Days | d. STREET ADDRESS (If outside, give location) 111 Robert Ave. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Alma Middle H. Last Schmidt | | | 4. DATE OF DEATH Month 12-19-58 Day Year | | |
| 5. SEX Female | 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 11-11-04 | 9. AGE (In years last birthday) 54 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | 11. BIRTHPLACE (City and state or country) Evansville, Ind. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME Victor Schon | | 13b. MOTHER'S MAIDEN NAME Lena Thuerback | | 14. NAME OF HUSBAND OR WIFE John B. Schmidt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address John B. Schmidt 111 Robert Ave. Ferguson | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF OVARY with Metastases | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 Months |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) _____ DUE TO (c) 175.0 | | | |
| 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 <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 <u>April 1958</u> to <u>Dec 19, 1958</u> and last saw her alive on <u>Dec 19, 1958</u> Death occurred at <u>8:15 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <i>Walter J. Kutryk, M.D.</i> (Degree or title) | | | 22b. ADDRESS 6000 W. Florissant | | 22c. DATE SIGNED 12-20-58 |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE 12-22-58 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis, Missouri |
| 24. FUNERAL DIRECTOR White-Mullen 118 N. Florissant Rd. | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. DEC 22 '58 | 26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> n.g.B. |

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 *Herbert J. Lane Jr.*

Licensed Embalmer No. *4800*

P. O. Address *Kirkwood 27*

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.