

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046283

STATE FILE NUMBER

FILED JAN 14 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12531

300
1-57

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 Clayton 4442
8. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Length of stay in 1b	d. STREET ADDRESS 27 225 North Meremac
3. NAME OF DECEASED (Type or print) First Middle Last ESTHER OONK SCHROEDER			4. DATE OF DEATH Month Day Year December 25th, 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 Oct. 22nd, 1893
9. AGE (In years last birthday) 65		FUNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Christ H. Oonk	13b. MOTHER'S MAIDEN NAME Helena Kramer
14. NAME OF HUSBAND OR WIFE Dr. George P. Schroeder		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Oliver Oonk		Address 7135 Pershing Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelogenous Leukemia, acute			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 2043			
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? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 12-25-58 to 12-25-58 and last saw her alive on 12/25/58 Death occurred at 10 pm 10 P. M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul O. Hagemann or title Paul O. Hagemann M.D.		22b. ADDRESS 3720 Washington Boulevard	22c. DATE SIGNED 12/25/1958
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE 12/27/1958	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum	23d. LOCATION (City, town, or county) (State) 7800 St. Charles Rock Road, Mo.
24. FUNERAL DIRECTOR C. R. LUPTON & SONS		ADDRESS 7233 DELMAR BLVD.	25. DATE RECD. BY LOCAL REG. DEC 27 '58
			26. REGISTRAR'S SIGNATURE Carl Smith - md acm

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.

3720 Washington Blvd.
Jefferson 1-6646
Hours: None

~~None~~

*Embalmed (7:30-10:00) in
place - No. 7-2845) at 7:30.
This evening. Dr. Thompson
will be back in town
will complete my certificate
on Thursday, Oct. 28, 1954.*

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 *Clarence A. Munn*

Licensed Embalmer No. *4011*

P. O. Address *St. Louis*

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.