

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003487

STATE FILE NUMBER

FILED JAN 28 1959

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 318

300
-57
38
093

3

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		Length of stay in lb D.O.A.	
3. NAME OF DECEASED (Type or print) First WALTER Middle J. Last SCHULTE		4. DATE OF DEATH Month Jan. Day 9 Year 1959	
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 July 2 1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Collection Officer		10b. KIND OF BUSINESS OR INDUSTRY Internal Revenue	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
13a. FATHER'S NAME John Schulte		13b. MOTHER'S MAIDEN NAME Emma Teckemeyer	14. NAME OF HUSBAND OR WIFE Irene Schulte (nee Osthoff)
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. 486-20-5003	17. INFORMANT Address Mrs. Irene Schulte, 1415a E. De Soto 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) Cardiac insufficiency			INTERVAL BETWEEN ONSET AND DEATH 30 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Subendocardial fibroelastosis			5 years.
DUE TO (c) Congenital heart disease - congenital complete atrio-ventricular block			34 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 754.2			19. WAS AUTOPSY PERFORMED? 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 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 January 25, 1957 to January 9, 1959 last saw him alive on January 9, 1959 Death occurred at 840 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John T. Lantow, M.D.		22b. ADDRESS 634 N. Grand Blvd.	22c. DATE SIGNED Jan 10, 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 1-12-59	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens	23d. LOCATION (City, town, or country) (State) St. Louis Co. Missouri.
24. FUNERAL DIRECTOR Math Hermann & Son, Inc., 2161 E. Fair		25. DATE RECD. BY LOCAL REG. JAN 12 '59	26. REGISTRAR'S SIGNATURE Carl Smith M.D.

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 *Clement M^c Neary*

Licensed Embalmer No. *3732*

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.