

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003503

STATE FILE NUMBER

FILED JAN 26 1959

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

237

300

-57

5

52

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.	
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 St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hosp.		Length of stay in lb 1 month	STREET ADDRESS (If outside, give location) 4245 Ellenwood Ave.
3. NAME OF DECEASED (Type or print) First HELEN Middle T. Last SHUTZ			4. DATE OF DEATH Month Jan. Day 6 Year 1959
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 Sept. 30 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Typist		10b. KIND OF BUSINESS OR INDUSTRY government	9. AGE (In years) 62
13a. FATHER'S NAME Edward Bergmann		13b. MOTHER'S MAIDEN NAME Ellen Byrne	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 500 26 6202	14. NAME OF HUSBAND OR WIFE Edgar P. Shutz
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Postoperative pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma, pelvic colon</u> DUE TO (c) <u>1538</u>			INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
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>Dec. 15, 1958</u> , to <u>Jan. 6, 1959</u> and last saw <sup>her</sup> alive on <u>Jan. 6, 1959</u> Death occurred at <u>9:50 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Grover Simon, M.D.</u> (Degree or title)		22b. ADDRESS <u>3700 Washington St.</u>	22c. DATE SIGNED JAN 8 '59
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 1/9/59	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) St. Louis County (State) Mo.
24. FUNERAL DIRECTOR Buchholz Mortuary 5967 W. Florissant		25. DATE RECD. BY LOCAL REG. JAN 8 '59	26. REGISTRAR'S SIGNATURE <u>Carl Smith mo</u>

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 *Wilfred G. Buckholz*

Licensed Embalmer No. *4557*

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.