Health, & Welfare Public Service

300-3
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003756
STATE FILE NUMBER

FILED JAN 19 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 32

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Clayton — Inside Limits Yes ☐ # No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Louis Co. Hosp D.O.A. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Breckenridge Hills 4060 — Inside Limits Yes # No ☐
d. STREET ADDRESS (If outside, give location): 3410 Rex — Reside on Farm Yes ☐ No #

3. NAME OF DECEASED (Type or print): First: Gottlieb Middle: F. Last: Scheible

4. DATE OF DEATH: Month: Jan. Day: 4 Year: 1959

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED # 2 DIVORCED ☐
8. DATE OF BIRTH: Aug. 15 1895
9. AGE (In years last birthday): 63 — IF UNDER 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): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Wagner Electric
11. BIRTHPLACE (City and state or country): Berger Missouri 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: The Late Elizabeth Scheible

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 490 28 8218
17. INFORMANT: Lucille Mues Address: 9429 Sequoia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4261
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 0

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 _____, to _____ and last saw her/him alive on _____
Death occurred at 3:19 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John C. Murphy M.D. Acting Health Commissioner
22b. ADDRESS: 801 S. Brentwood Clayton, Mo.
22c. DATE SIGNED: 1/9/59

23a. BURIAL, CREMATION, REMOVAL: Burial
23b. DATE: 1)7)59
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Mo.

24. FUNERAL DIRECTOR: Collier Mortuary ADDRESS: St. Ann, Mo.
25. DATE RECD. BY LOCAL REG.: 1-5-59
26. REGISTRAR'S SIGNATURE: Herbert R. Omke M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann M

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.