

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003897
STATE FILE NUMBER

FILED JAN 12 1959

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 10

300
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u>		c. CITY OR TOWN <u>Webster Groves</u> ^{4/17}	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>122 E. Jackson Rd.</u>		d. STREET ADDRESS (If outside, give location) <u>122 E. Jackson Rd.</u>	
Length of stay in lb <u>5 1/2 yrs</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Caroline</u> Last <u>Schulz</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1879</u>	9. AGE (In years last birthday) <u>79</u>	10. F UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Otto Theiss</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Wagner</u>	14. NAME OF HUSBAND OR WIFE <u>Edward Schulz</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>491-12-9638B</u>	17. INFORMANT <u>Clarence Schulz</u> Address <u>122 E. Jackson Rd.</u>
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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>carcinoma of stomach with generalized metastasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>
DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>151X</u>		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.) <u>ITEM 22c CORRECTED</u>
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	BY AFFIDAVIT OF <u>Physician</u> <u>1-23-59</u>
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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 _____
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21. I attended the deceased from 5-13-1955 to 1-1-59 and last saw her alive on 12-31-58
Death occurred at 3:45 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Declaror title) <u>Emmorth A. Westrup M.D.</u>	22b. ADDRESS <u>204 E. Big Bend</u>	22c. DATE SIGNED <u>1-2-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-3-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Louis Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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24. FUNERAL DIRECTOR <u>Mittelberg Funeral Home</u> ADDRESS <u>Webster Groves, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-2-59</u> REGISTRAR'S SIGNATURE <u>Herbert L. Blank, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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.

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 *Stanley H. Dixon*

Licensed Embalmer No. *4193*
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.