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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007614

STATE FILE NUMBER 2 1667

FILED MAR 2 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis, Missouri — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 1026 Veronica Ave, — Length of stay in 1b Years	d. STREET ADDRESS (If outside, give location) 1026 Veronica Ave., — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First: William	Middle: A.	Last: Schnatzmeyer	4. DATE OF DEATH Month Day Year: February 15, 1959
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: 2-23-1891
9. AGE (In years last birthday): 67	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): Retired Wood Worker	10b. KIND OF BUSINESS OR INDUSTRY: Rice-Stix, Company	11. BIRTHPLACE (City and state or country): St. Louis, County, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Herman Schnatzmeyer	13b. MOTHER'S MAIDEN NAME: Charlotte Benne	14. NAME OF HUSBAND OR WIFE: Mrs Catherine Schnatzmeyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. I	16. SOCIAL SECURITY NO.: 489-07-1865	17. INFORMANT Address: Mrs Catherine Schnatzmeyer, 1026 Veronica Ave	

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) Carcinoma Lungs, Liver Skin et al — INTERVAL BETWEEN ONSET AND DEATH 2 yrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 199.2

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? YES [ ] NO [X] 2

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 Jan 1-1957, to 2-15-59 and last saw her/him alive on 2/15/59

Death occurred at 4:30 A.M., m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William A Kirk M.D.	22b. ADDRESS 8201 N Broadway	22c. DATE SIGNED 2-16-59
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2-18-1959	23c. NAME OF CEMETERY OR CREMATORY: Friedens Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri.		
24. FUNERAL DIRECTOR ADDRESS: Math. Hermann & Son Inc. 2161 E. Fair Ave.	25. DATE RECD. BY LOCAL REG.: FEB 17 '59	26. REGISTRAR'S SIGNATURE: Carl Smith, M.D. MDB

(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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.