

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011372

STATE FILE NUMBER

FILED MAR 27 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. **2601**

b. 300
1-57

797

c

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 SAINT LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN SAINT LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		Length of stay in lb 3 DAYS		d. STREET ADDRESS (If outside, give location) 4128 WALBRIDGE PL. 15		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLA Middle MARGARET Last SCHRIEWER			4. DATE OF DEATH Month MARCH Day 13 Year 1959				
5. SEX FEMALE	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 AUG. 18, 1882	9. AGE (In years last birthday) 76 YRS.	10. FUNDER YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (City and state or country) ST. JACOB, ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME MIKE BERNHARDT			13b. MOTHER'S MAIDEN NAME MARY SCHMITT			14. NAME OF HUSBAND OR WIFE JOSEPH T. SCHRIEWER	
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. UNKNOWN		17. INFORMANT Address MR. JOSEPH SCHRIEWER, 4128 WALBRIDGE PL. 15			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage & Coma						INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) Hypertension						15 yrs	
DUE TO (c) Atherosclerotic Cordis Vas disease						more than 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 445X						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.)				
20c. TIME OF INJURY Hour 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 1944 to March 13, 1959 and last saw her/him alive on March 12, 1959 . Death occurred at 4:15 A. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE St. C. A. Leudeman M.D. (Degree or title)				22b. ADDRESS 4126th Shen Ave		22c. DATE SIGNED 3/13/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE MARCH 16, 1959	23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MISSOURI.		
24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 NAT'L BRIDGE BLVD.				25. DATE RECD. BY LOCAL REG. MAR 13 '59		26. REGISTRAR'S SIGNATURE Earl Smith, M.D. <i>mfb</i>	

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 *John A. Mlesnar*
Licensed Embalmer No. *4186*

P. O. Address *St. Louis, Mo.*

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.