

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016082

STATE FILE NUMBER

FILED MAY 8 1959

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 1244

Health, Welfare Public Service

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Vector, coroner, etc. must use only steno-graph nomenclature in this. No symptoms will be listed. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY ST. CHARLES	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON		c. CITY OR TOWN WENTZVILLE ⁰⁹²⁰	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CO. HOSP.		d. STREET ADDRESS (If outside, give location) 113 CHERYL ANN DR	
3. NAME OF DECEASED (Type or print) First Clinton Middle H. Last Schue		4. DATE OF DEATH Month May Day 4 Year 1959	
5. SEX MALE	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 AUG. 29, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATIONERY FIREMAN-UNITED DRUG CO.		10b. KIND OF BUSINESS OR INDUSTRY Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME SCHUE UNKNOWN	14. NAME OF HUSBAND OR WIFE LATE ELIZABETH SCHUE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 488-05-0254	17. INFORMANT Address LEO BLADES 3604 BEYER AVE.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mucous tracheo bronchitis DUE TO (b) chronic pulmonary disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 501X			INTERVAL BETWEEN ONSET AND DEATH 1
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. Month, Day, Year _____		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 5-1-59 to 5-4-59 and last saw her alive on 5-4-59 Death occurred at 6:40 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Emil Maurin (Degree or title) 0		22b. ADDRESS 6015 Brentwood, Clayton Mo.	
22c. DATE SIGNED		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE 5-6-59		23c. NAME OF CEMETERY OR CREMATORY FEE FEE CEM.	
23d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO		24. FUNERAL DIRECTOR ADDRESS KRIEGSHAUSER 4228 S. KINGSHIGHWAY	
25. DATE RECD. BY LOCAL REG. 5-5-59		26. REGISTRAR'S SIGNATURE John C. Murphy M.D.	

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 ... *Richard W. Stovesand*

Licensed Embalmer No. *4007*

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.