

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-1-16357
STATE FILE NUMBER

MAY 7 1959

Registration District No. 317

Primary Registration District No. 680

Registrar's No. 942

300
-57
Melba Blug.
3608 S. Grand
PR 207891

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Gardenville		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. 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 Miller Nursing Home 1 Wk		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 3981 A. Schiller Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last PETER SCHULTZ			4. DATE OF DEATH Month Day Year 4-5-1959
5. SEX Male	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 11-14-1875
9. AGE (In years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (City and state or country) Hungary
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Peter Schultz		13b. MOTHER'S MAIDEN NAME Anna Moore	14. NAME OF HUSBAND OR WIFE Anna Schultz
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. 493-30-7417	17. INFORMANT Address Anna Schultz 3981 Schiller Pl
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency and Acute Myocarditis . Chronic Arteriosclerosis and Chronic Interstitial Nephritis			INTERVAL BETWEEN ONSET AND DEATH 2 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) and Chronic Interstitial Nephritis			1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 422.1			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.) 422.1	
20c. TIME OF INJURY . Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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 March 27th '59 to Apr. 5 '59 and last saw her/him alive on Apr. 4th, 1959 Death occurred at 3:05 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) M. A. Walters M.D.		22b. ADDRESS 3608 S. Grand Blvd.,	22c. DATE SIGNED 4/6/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-8-1959	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) McKenzie Rd and H1.66 Mo.
24. FUNERAL DIRECTOR Regenthem Bros		ADDRESS 6409 Gravois Ave	25. DATE RECD. BY LOCAL REG. 4-7-59 26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 *Van M. Sigerson*
Licensed Embalmer No. 4343

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.