

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019603

STATE FILE NUMBER

FILED JUN 1 1959

Registration District No. _____ Primary Registration District No. _____

Registered No. 4807

300
-57
25
9/

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 St. Louis		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 St. John's Hospital		Length of stay in lb 5 weeks	d. STREET ADDRESS (If outside, give location) 4427 Farlin Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Agnes Middle D. Last Schnelle			4. DATE OF DEATH Month May Day 16 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 Dec. 31, 1897	9. AGE (In years last birthday) 61	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) New York City, New York		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James J. Ballard		13b. MOTHER'S MAIDEN NAME Mary Ann Clements		14. NAME OF HUSBAND OR WIFE Alfred Schnelle		
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. None		17. INFORMANT Address Alfred Schnelle 4427 Farlin 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) Basilar artery thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 month
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) cerebral arteriosclerosis	2 yrs?
	DUE TO (c) 332+	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteritis Mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 St. Louis	COUNTY St. Louis	STATE Missouri
21. I attended the deceased from Dec 11 1949 to 5-16-59 and last saw her alive on 5-15-59 . Death occurred at 4:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Deedee or title) William A. Hermann M.D.	22b. ADDRESS 4401 Hampton	22c. DATE SIGNED 5-16-59
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 19, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
--	----------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son Inc. 2161 E. Fair	25. DATE RECD. BY LOCAL REG. MAY 18 '59	26. REGISTRAR'S SIGNATURE Neal Smith, M.D. <i>S.P.</i>
---	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Glen W. Noy*
Licensed Embalmer No. *30937*
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.