

XC-19 359 434

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020028  
STATE FILE NUMBER

FILED JUN 12 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1433

S. 300

1-57

58

304

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 <b>ST. LOUIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS MO.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Vet. Adm. Hospital</b>		Length of stay in lb <b>32 days</b>		d. STREET ADDRESS (If outside, give location) <b>2301 1/2 So. 10th Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>M.</b> Last <b>SCHINDLER</b>				4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>59</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-5-90</b>		9. AGE (In years past birthday) <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAWYER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LAW</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>FRANK A. SCHINDLER</b>			13b. MOTHER'S MAIDEN NAME <b>MARIE JOERG</b>			14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or if unknown) (If yes, give type or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO. <b>496 362532A</b>		17. INFORMANT Address <b>VA HOSP. RECORDS, JEFFERSON BARRACKS, MO.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENO CARCINOMA OF RECTO-SIGMOID</b>						INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CARDIAC DECOMPENSATION</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <b>4-20-59</b> , to <b>5-22-59</b> and <del>resided with him</del> Death occurred at <b>9:45 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Type or print) <b>Geo. Sigmund Neukom Acting Dir. Prof. Services</b>						22b. ADDRESS <b>VA HOSP. JEFFERSON BARRACKS, MO.</b>	
						22c. DATE SIGNED <b>5-22-59</b>	
23a. MANNER OF CREATION <b>Burial</b>		23b. DATE <b>5/25/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>S S Peter &amp; Paul</b>		23d. LOCATION (City, town, or county) (State) <b>St Louis Missouri</b>	
24. FUNERAL DIRECTOR <b>Moydell Funeral Home 1926 Allen</b>				25. DATE RECD. BY LOCAL REG. <b>5-23-59</b>		26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>	

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 *Halley D. Jaeller, Jr* .....

Licensed Embalmer No. *4950* .....

P. O. Address *St. Louis* .....

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.