

FILED JUL 13 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023369

STATE FILE NUMBER

Registration District No. Primary Registration District No.

Registrar No. 6032

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, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital DOA		Length of stay in 1b.	d. STREET ADDRESS (If outside, give location) 5123a So. Compton, Ave.
3. NAME OF DECEASED (Type or print) First Anna Middle Last Schmitt		4. DATE OF DEATH Month June Day 17 Year 1959	
5. SEX Female	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 July 26, 1889
9. AGE (In years last birthday) 69		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 At Home	11. BIRTHPLACE (City and state or country) Hungary
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Edw.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. 486-18-8791	17. INFORMANT Address V. Schmitt, 2204 Hord, 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) Cardiac Failure DUE TO (b) Chronic Myocarditis DUE TO (c) 422.2 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Malnutrition			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
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 6-12-59 to 6-17-59 and last saw her alive on 6-12-59 Death occurred at 9:22 p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE CA Nestor MD Degree or title		22b. ADDRESS 5800 S Compton	22c. DATE SIGNED 6-25-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-26-59	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington,		25. DATE RECD. BY LOCAL REG. JUN 25 '59	26. REGISTRAR'S SIGNATURE Mrs. Carol Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300

1-57

95

no symptoms with 11818

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 *Gay W. Williams*

Licensed Embalmer No. *3525*
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.