

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027165

FILED VS AUG 13 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7164** STATE FILE NUMBER

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		Length of stay in 1b 5 weeks	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 Bethesda Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4431 S. Broadway Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Azie Middle Adele Last Schmitt	4. DATE OF DEATH Month July Day 31 Year 1959
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5. SEX Female	6. COLOR OR RACE Caucasian	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/19/1887	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Carl Weymouth	13b. MOTHER'S MAIDEN NAME Johanna Meier	14. NAME OF HUSBAND OR WIFE Louis F.H. Schmitt
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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. _____	17. INFORMANT Address Home of the Friendless, 4431 S. Broadway
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Decubitus ulcer with massive infection of coagulase positive staphylococcus aureus		29 days
DUE TO (b) Intertrochanteric fracture of the right femur		6/23/59
DUE TO (c) ----- 9027-45		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) -----	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Fell off porch at Home of Friendless
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20c. TIME OF INJURY Hour _____ ? a.m. _____ p.m. 6:23-59	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.) 156 Home 4431 S. Broadway St. Louis, Mo.	20f. CITY, TOWN, OR LOCATION St. Louis, Mo.	COUNTY St. Louis	STATE Mo.
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21. I attended the deceased from April 15, 1959 to July 31, 1959 and last saw her alive on July 30, 1959 Death occurred at 3:50 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Benjamin N. Chack M.D.	22b. ADDRESS 3720 Washington Blvd. St Louis	22c. DATE SIGNED 8/3/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/3/1959	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY 6464 CHIPPEWA ST. ST. LOUIS, MO.	25. DATE RECD. BY LOCAL REG. AUG 3 59	26. REGISTRAR'S SIGNATURE Earl Smith M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John J. Deener

Licensed Embalmer No. 4194

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.