

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

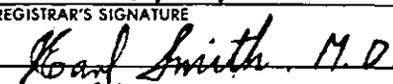
FILED JUL 17 1959

59-027171

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **6355**

DEED

<b>1. PLACE OF DEATH</b> a. COUNTY _____		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>	Length of stay in 1b _____	c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Christian Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1525 Mallinckrodt</b>
<b>3. NAME OF DECEASED</b> First Middle Last <b>Elizabeth F. Schniedermeier</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>7-4-1959</b>
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1-31-1876</b>
<b>9. AGE</b> (last birthday) <b>83</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Louis, Mo</b>
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A.</b>			<b>13a. FATHER'S NAME</b> <b>Chris Walkenford</b>
<b>13b. MOTHER'S MAIDEN NAME</b> <b>Anna Summers</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Deceased</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT</b> Address <b>John Schniedermeier - 1525 Mallinckrodt</b>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pneumonia</b>			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
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m.	Month, Day, Year	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	COUNTY	STATE
<b>21. I attended the deceased from</b> <b>June 4, 1955</b> to <b>July 4, 1959</b> and last saw her <sup>him</sup> alive on <b>July 3, 1959</b> . Death occurred at <b>5:10 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
<b>22a. SIGNATURE</b> 		(Degree or title)	<b>22b. ADDRESS</b> <b>4222 N. Grand</b>
<b>22c. DATE SIGNED</b> <b>7-6-59</b>			<b>23a. BURIAL, CREMATION, OR DISPOSAL</b> (Specify) <b>Burial</b>
<b>23b. DATE</b> <b>7-7-1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Calvary Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis, Mo</b>	<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Edw. Koch &amp; Son - 3516 E. 14th</b>
<b>25. DATE RECD. BY LOCAL REG.</b> <b>JUL 6 '59</b>		<b>26. REGISTRAR'S SIGNATURE</b> 	

(Licensed Embalmer's Statement on Reverse Side)

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

*Gustavo W. Sierente*

Licensed Embalmer No. *432*

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.