

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 24 1959

59-027178

Registration District No. _____ Primary Registration District No. _____ Registrar No. **6352** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 603 1/2 Garesche Ave.	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First ALVINA Middle SCHULTZ Last			Month July Day 3 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 3/20/1882	9. AGE (last birthday) 77	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework			10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and state or country) Germany	Months	Days
				12. CITIZEN OF WHAT COUNTRY U.S.A.		

13a. FATHER'S NAME Carl Hetzel	13b. MOTHER'S MAIDEN NAME Justine Trochler	14. NAME OF HUSBAND OR WIFE
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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. none	17. INFORMANT Alma Braun Address 603 1/2 Garesche Ave.
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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) Cerebral thrombosis		4 wks
DUE TO (b) Generalized arteriosclerotic cardio-vascular disease (advanced)		?
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cystitis		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 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.) 422.1
20c. TIME OF INJURY Hour Month, Day, Year 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 COUNTY STATE
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21. I attended the deceased from **2-4-52** to **7-3-59** and last saw her/him alive on **7-3-59**
Death occurred at **10:40 a.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. J. Mueller, M.D.	22b. ADDRESS 634 N. Grand Blvd.	22c. DATE SIGNED 7/6/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 7/6/59	23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
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24. FUNERAL DIRECTOR Buchholz Mortuary 5967 W. Florissant	25. DATE RECD. BY LOCAL REG. JUL 6 '59	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mjs

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 W E Morris

Licensed Embalmer No. 3360

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.