

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH 59-027473

FILED VS AUG 3 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1945 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton,</u>		Length of stay in 1b <u>5 HRS.</u>	c. CITY OR TOWN <u>MOLINE ACRES</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2229 KERWIN DR.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>C.</u> Last <u>Schnitzmeyer</u>			4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1959</u>		
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5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-13-82</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>5</u> Min. <u>10</u>	IF UNDER 24 HR Hours <u>5</u> Min. <u>10</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATE TILE ROOFER-BERGER ROOFING CO</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOFFMAN, ILL.</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>FRED SCHNITZMEYER</u>	13b. MOTHER'S MAIDEN NAME <u>LOUISE JOHANSMEYER</u>	14. NAME OF HUSBAND OR WIFE <u>DR.</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>OTTO SCHNITZMEYER</u> Address <u>2229 KERWIN DR.</u>
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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)	<u>Cerebral Thrombosis</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral arteriosclerosis</u>	
	DUE TO (c) <u>Generalized arteriosclerosis</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive Cardiovascular Disease</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year <u>7-18-59</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>ST. LOUIS, MO.</u>	COUNTY _____ STATE _____
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21. I attended the deceased from 7-18-59 to 7-19-59 and last saw him alive on 7-19-59
Death occurred at 1:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul W. Schaper M.D.</u>	22b. ADDRESS <u>6015 Brentwood Blvd.</u>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>7-22-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CONCORDIA CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO.</u>
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24. FUNERAL DIRECTOR <u>KRIEGSHAUSER</u> ADDRESS <u>4228 S. KINGS HIGHWAY</u>	25. DATE RECD. BY LOCAL REG. <u>7-20-59</u>	26. REGISTRAR'S SIGNATURE <u>J. B. Murphy M.D.</u>
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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 R. W. Storesand

Licensed Embalmer No. 4007

P. O. Address _____

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.