

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027497

FILED VS AUG 1 0 1959

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 20160 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>Jennings</u>		Length of stay in 1b <u>1 year</u>		c. CITY OR TOWN <u>Jennings</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>9246 Sundown</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>9246 Sundown</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>F.</u> Last <u>Schulte</u>				4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1959</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1/8/1890</u>	9. AGE (last birthday) <u>69 yrs.</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph Schulte</u>			13b. MOTHER'S MAIDEN NAME <u>Theresa Lakenburger</u>			14. NAME OF HUSBAND OR WIFE <u>Anna Helen Schulte</u>		
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>702-12-5344</u>		17. INFORMANT Address <u>Anna Helen Schulte 9246 Sundown</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>concurrent</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Hypertensive cardiac-vascular disease</u>						
		DUE TO (c) _____						
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 type="checkbox"/> No <input type="checkbox"/> Unknown		
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.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____								
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	
21. I attended the deceased from <u>Nov - 1958</u> to <u>July 31-1959</u> and last saw him alive on <u>July 30-59</u> Death occurred at <u>10:00</u> <u>am</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Karl F. Keffler M.D.</u>				22b. ADDRESS <u>1139 Bellevue av.</u>			22c. DATE SIGNED <u>Aug 1-59</u>	
23b. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Dominics Cemetery</u>	23d. LOCATION (City, town, or county) <u>Bresse Ill.</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Buchholz Mort. 5967 W. Florissant Av.</u>			25. DATE RECD. BY LOCAL REG. <u>8-1-59</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>			

(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 Wilford A. Bensch

Licensed Embalmer No. 4537

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.