RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–030767

FILED VS AUG 24 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7155

DED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Missouri, St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Marian Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3215 Oregon
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Minnie M. Schlueter
4. DATE OF DEATH Month Day Year: Jul. 30, 1959
5. SEX: female
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Jul 25, 1883
9. AGE (last birthday): 76
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): none
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Unk. Stowers
13b. MOTHER'S MAIDEN NAME: unk
14. NAME OF HUSBAND OR WIFE: Fred G. Schlueter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Frederick G. Schlueter
Address: 3215 Oregon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease
DUE TO (b): —
DUE TO (c): — 420.0
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

O.K. Paul Johnson Deputy Coroner 8/

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Decubitus ulcer + cardiac arrhythmia
Liver
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 10 55 A.M. 7/30/59 7/30/59 and last saw her alive on 7/30/59
Death occurred at 10 55 A.M. 7/30/59 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): William R. Platt, M.D.
22b. ADDRESS: 919 N. Taylor Ave.
22c. DATE SIGNED: 7/30/59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 8-3-59
23c. NAME OF CEMETERY OR CREMATORY: St. Pauls Churchyard
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: Southern Funeral Home
ADDRESS: 6322 S. Grand, St. Louis, Mo.
25. DATE RECD. BY LOCAL REG.: AUG 3 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4242

P. O. Address St Louis Mo

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