

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030780

FILED VS SEP 4 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7715** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital, DOA			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4754 Bichelberger		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) George R Schuler				4. DATE OF DEATH Month August Day 17 Year 1959									
5. SEX male		6. COLOR OR RACE white		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/17/1904		9. AGE (last birthday) 55		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) retired				10b. KIND OF BUSINESS OR INDUSTRY truck driver				11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Frank J Schuler				13b. MOTHER'S MAIDEN NAME Martha Kettinger				14. NAME OF HUSBAND OR WIFE none					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II				16. SOCIAL SECURITY NO. 581.0		17. INFORMANT Address John E Schuler 3313 Wisconsin							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic degenerative Myocarditis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic interstitial Nephritis DUE TO (c) Cirrhosis of the Liver										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 581.0								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 checked="" type="checkbox"/> NO <input 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 St. Louis		COUNTY St. Louis		STATE Mo.	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on _____ at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>John E Schuler</i> (Degree or title) Deputy						22b. ADDRESS 1300 Clark			22c. DATE SIGNED 8/20/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 8/20/1959		23c. NAME OF CEMETERY OR CREMATORY National Cemetery				23d. LOCATION (City, town, or county) St. Louis County, Mo.			
24. FUNERAL DIRECTOR John L Ziegenhein & Sons ADDRESS 7027 Gravois				25. DATE RECD. BY LOCAL REG. SEP 20 1959				26. REGISTRAR'S SIGNATURE <i>Loal Smith - M.D.</i>			

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 C. D. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Hawaii

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.