

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031051
STATE FILE NUMBER

FILED VS SEP 8 1959 317
Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2327

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BERKELEY</u>	Length of stay in 1b <u>23 DAYS</u>	c. CITY OR TOWN <u>FLORISSANT</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>PENN NURSING HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>920 ST. MARIE</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>MAX</u> Middle <u>-</u> Last <u>SCHMIDT</u>			4. DATE OF DEATH Month <u>AUGUST</u> Day <u>28</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>12-17-1887</u>	9. AGE (last birthday) <u>71</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>CABINET MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REFRIGERATION</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>SCHMIDT</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>PAULA SCHMIDT</u>					

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>499-01-1362</u>	17. INFORMANT <u>PHILLIP BRISLANE, FLORISSANT, MO.</u>
---	--	---

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 thromboses</u>		<u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Cardiovascular disease</u>	<u>unknown</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) <u>Old right hemiplegia</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	
--	--	--	--

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>August 8, 1959</u> to <u>Aug 28, 1959</u> and last saw ^{her} him alive on <u>Aug 27, 1959</u> Death occurred at <u>7:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE (Degree or title) <u>Lewis Littmann MD</u>		22b. ADDRESS <u>8231 Clayton Rd (17)</u>	22c. DATE SIGNED <u>8/29/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-31-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, MO.</u>

24. FUNERAL DIRECTOR <u>THE FLORISSANT MORTUARY, FLORISSANT, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>8-29-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy, M.D.</u>
---	--	--

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 Gene A. Hutchens

Licensed Embalmer No. 4966

P. O. Address FLORISSANT,

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.