URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 28 1959

59–034659

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 2520

ENDED

1. PLACE OF DEATH
a. COUNTY: ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: WEST OVERLAND
Length of stay in 1b: 3 1/2 YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 11116 N. WARSON
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO
b. COUNTY: ST LOUIS
c. CITY OR TOWN: WEST OVERLAND
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 11116 N WARSON
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First FRED Middle C Last SCHULTHEIS
4. DATE OF DEATH: Month 9 Day 20 Year 59
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 12-15-73
9. AGE (last birthday): 85
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): WATCHMAN
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (City and state or country): BELLEVILLE ILL.
12. CITIZEN OF WHAT COUNTRY: U.S.A
13a. FATHER'S NAME: FRED SCHULTHEIS
13b. MOTHER'S MAIDEN NAME: CHRISTINE (unknown)
14. NAME OF HUSBAND OR WIFE: CLARA SCHULTHEIS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 492-05-0792
17. INFORMANT: Roy SCHULTHEIS Address: 11116N.WARSON

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): C.V.A. Cerebral Vascular accident
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c): Arteriosclerosis
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)
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 Jan. 1959, to Sept 1959 and last saw him alive on Sept 1, 1959.
Death occurred at 9-20-59 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: L. Rudolph Williams Jr. D.O. (Degree or title)
22b. ADDRESS: 10426 Lackland Rd.
22c. DATE SIGNED: 9-21-59

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 9-23-59
23c. NAME OF CEMETERY OR CREMATORY: CALVARY
23d. LOCATION (City, town, or county): ST LOUIS (State): MO

24. FUNERAL DIRECTOR: EARL HILLEMAN ADDRESS: 9709 LACKLAND
25. DATE RECD. BY LOCAL REG.: 9-22-59
26. REGISTRAR'S SIGNATURE: John C. Murphy 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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 501

P. O. Addres _____

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