

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038528

FILED VS NOV 2 1959

317

Registration District No. 500

Registrar's No. 2758

STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Manchester</b>		c. CITY OR TOWN <b>Brentwood</b>	
Length of stay in 1b <b>3 months</b>		Inside Limits <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Manchester Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>1411 Peacock</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>TINA</b> Middle <b>MAGNOLIA</b> Last <b>SCHULTZ</b>			4. DATE OF DEATH Month <b>October</b> Day <b>18</b> Year <b>1959</b>	
---	--	--	---	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/22/98</b>	9. AGE (last birthday) <b>61</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
----------------------	-------------------------------	---	---------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Chiropractor</b>	11. BIRTHPLACE (City and state or country) <b>Tennessee</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
--	---	---	--

13a. FATHER'S NAME <b>Samuel Skaggs</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Long</b>	14. NAME OF HUSBAND OR WIFE <b>Frank Schultz</b>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>533638-8828</b>	17. INFORMANT <b>Dr. F. E. Schultz, 1411 Peacock, Brentwood, Mo</b>	Address
--	--	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-VASCULAR DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
DUE TO (b) _____		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal chronic condition given in PART I (a) <b>CHRONIC RHEUMATOID ARTHRITIS</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 **JULY 15, 1959** to **OCT. 18, 1959** and last saw her **alive on OCT. 17, 1959**  
Death occurred at **3:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>B. R. Loving</b> (Degree or title) <b>M. D.</b>	22b. ADDRESS <b>BALLWIN, Mo.</b>	22c. DATE SIGNED <b>10.19.59</b>
---	----------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/19/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Seattle, Wash.</b>
--	---------------------------	--	---

24. FUNERAL DIRECTOR <b>Louis H. Popp Inc</b> ADDRESS <b>Richard</b>	25. DATE RECD. BY LOCAL REG. <b>10-19-59</b>	26. REGISTRAR'S SIGNATURE <b>J. B. Murphy M.D.</b>
--	--	--

(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 me  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Francis J. Weyland  
Licensed Embalmer No. 4512

P. O. Address Richwood

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.