OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 0 1959

59-042466

STATE FILE NUMBER

MENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210687

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5957 Wanda Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First GEORGE; Middle; Last SCHENKEL
4. DATE OF DEATH: Month Nov.; Day 19; Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10-15-1904
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): Ass't. Sec'y.-Mercantile
10b. KIND OF BUSINESS OR INDUSTRY: Commerce Bank&Trust Co.
11. BIRTHPLACE (City and state or country): St.Louis,Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: William Schenkel
13b. MOTHER'S MAIDEN NAME: Katie Kimmich
14. NAME OF HUSBAND OR WIFE: Minnie Schenkel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 497-16-6735
17. INFORMANT: Minnie Schenkel
Address: 5957 Wanda Ave.

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): POLYCYTHEMIA VERA
INTERVAL BETWEEN ONSET AND DEATH: ??
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 294X
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 Nov. 4, 1959, to Nov. 19, 1959 and last saw ~~her~~ him alive on Nov. 18, 1959
Death occurred at 5:45 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: William A. Ruzicka M.D. (Degree or title)
22b. ADDRESS: 3720 WASHINGTON
22c. DATE SIGNED: 11/19/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Nov.21,1959
23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: Kriegshauser
ADDRESS: 4228 S.Kingshighway
25. DATE RECD. BY LOCAL REG.: NOV 19 1959
26. REGISTRAR'S SIGNATURE: Paul Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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. 4533

P. O. Address _____

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.