URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-042475

FILED VS NOV 3 0 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210672

ENDED

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. Anthony Hospital,
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri, b. COUNTY
c. CITY OR TOWN St. Louis,
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 4830 Pennsylvania Ave.,
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Jo-Ann Middle: Schnurbusch Last:
4. DATE OF DEATH Month Day Year: November 18, 1959
5. SEX: Female.
6. COLOR OR RACE: White,
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10/8/59
9. AGE (last birthday)
IF UNDER 1 YEAR: Months 1 Days 10
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St. Louis, Missouri,
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Joseph O. Schnurbusch,
13b. MOTHER'S MAIDEN NAME: Birdella Ann Buerck,
14. NAME OF HUSBAND OR WIFE: ----------
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.: None
17. INFORMANT: Joseph O. Schnurbusch, Address: 4830 Pennsylvania A

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) Heart Failure, Congestive — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Congenital Heart Disease (3 chambered heart)
DUE TO (c) 754.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Pneumonitis

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 Oct 8, 1959, to Nov 18, 1959 and last saw her ~~him~~ alive on Nov 18, 1959
Death occurred at 11:55 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [illegible] MD
22b. ADDRESS 5438 So Grand
22c. DATE SIGNED 11/19/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE NOV 19 1959
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) Perryville, Missouri (State)

24. FUNERAL DIRECTOR ADDRESS Gebken-Benz Mortuary, 2842 Meramec St., St. Louis, 18, Mo.
25. DATE RECD. BY LOCAL REG. NOV 19 1959
26. REGISTRAR'S SIGNATURE Earl Smith, M.D. MDC

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

Mestres
3438 So Grand.

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_____ Signed Joe S. Benz
Signature of Student Embalmer

Licensed Embalmer No. 4249

******** NO EMBALMING********

P. O. Address 2842 Meramec St. St. Louis, 18, 1

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