

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS NOV 3 0 1959

210743 **59-042481**
 STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 24 days	c. CITY OR TOWN Labadie
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis-Little Rock Hosp., Inc.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) General Delivery

3. NAME OF DECEASED (Type or print) First August Middle William Last Schueller	4. DATE OF DEATH Month November Day 20 Year 1959
--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-15-1876	9. AGE (last birthday) 82	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) Penstr. Jt. Express Messenger	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) St. Louis Co., Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	--	---	--

13a. FATHER'S NAME Wm. J. Schueller	13b. MOTHER'S MAIDEN NAME Caroline Rahm	14. NAME OF HUSBAND OR WIFE Clara Schueller
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. unk.	17. INFORMANT Otto Schueller	Address Pacific, Mo.
---	--	--	--------------------------------

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) Rt Hemiplegia	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) Generalized Arteriosclerosis	
DUE TO (c) Senility	334X

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. <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 October 28, 1959 to November 20, 1959 and last saw him alive on November 19, 1959
Death occurred at 7:35 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Wm O</i>	(Degree or title)	22b. ADDRESS 1755 S. Grand Blvd	22c. DATE SIGNED 11-20-59
-------------------------------	-------------------	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-22-59	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
---	------------------------------	---	--

24. FUNERAL DIRECTOR Schrader Funeral Home	ADDRESS Ballwin, Mo.	25. DATE RECD. BY LOCAL REG. NOV 21 1959	26. REGISTRAR'S SIGNATURE <i>Red Smith, M.D.</i>
--	--------------------------------	--	---

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 Richard M. Bypp

Licensed Embalmer No. 4584

P. O. Address Ballwin

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.