

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042832

FILED VS DEC 3 1959

Registration District No. 517 Primary Registration District No. 544 Registrar's No. 3104

STATE FILE NUMBER

INDEXED

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u> | | Length of stay in 1b <u>4 da.</u> | c. CITY OR TOWN <u>Pacific R. 7.D 2</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>3 mi. north.</u> |
| | | Yes <input type="checkbox"/> No <input type="checkbox"/> | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Jewel</u> Last <u>Schuster</u> | | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>23</u> Year <u>1959</u> | |
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|-----------------|----------------------------|---|--|-------------------------------------|---|----------------|
| 5. SEX <u>F</u> | 6. COLOR OF RACE <u>wh</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 21, 1897</u> | 9. AGE (last birthday) <u>62</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
|-----------------|----------------------------|---|--|-------------------------------------|---|----------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (City and state or country) <u>Pettis Co.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> |
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| 13a. FATHER'S NAME <u>Jas. Whiting</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary Jane Weckins</u> | 14. NAME OF HUSBAND OR WIFE <u>Ervin Schuster (deceased)</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>none</u> | 17. INFORMANT <u>John Schuster (son)</u> | Address <u>Pacific Mo</u> |
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| 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) | <u>Massive Cerebral hemorrhage</u> | <u>7 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | <u>2</u> |
| | <u>Arteriosclerosis hypertensive heart dis.</u> | |
| | DUE TO (c) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u> | 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 |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.) |
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| 20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u> | Month, Day, Year |
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|--|--|------------------------------|--------|-------|
| 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 17th of Nov 1959 to Nov 23-59 and last saw her alive on Nov 22 Nov 1959
Death occurred at 1154 N Nov 23 m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>J. Brewer MD</u> | (Degree or title) | 22b. ADDRESS <u>Pacific Mo</u> | 22c. DATE SIGNED <u>11/23/59</u> |
|---------------------------------------|-------------------|-----------------------------------|-------------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov 25 '59</u> | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY <u>Bush Creek</u> | 23d. LOCATION (City, town, or county) (State) <u>Gray Summit Mo</u> |
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| 24. FUNERAL DIRECTOR <u>Mrs. John L. Shuler</u> | ADDRESS <u>Pacific Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>NOV 23 1959</u> | 26. REGISTRAR'S SIGNATURE <u>John B. Murphy MD</u> |
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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 Ralph Altman

Licensed Embalmer No. 4808

P. O. Address Union, Mo

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.