

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 9 0 9

FILED VS JAN - 4 1960

211807

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) a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS,		Length of stay in 1b		c. CITY OR TOWN ST LOUIS,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MISSOURI BAPTIST HOSP			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5100 a THEKLA AVE			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HARRY Middle A. Last SCHER				4. DATE OF DEATH Month DEC, Day 19, Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7/9/1894	9. AGE (last birthday) 65	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) RETIRED TEACHER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) NEW YORK N. Y.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME UNKNOWN			13b. MOTHER'S MAIDEN NAME UNKNOWN			14. NAME OF HUSBAND OR WIFE KATHRYN SCHER	
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. #	17. INFORMANT Address KATHRYN SCHER 5100 a THEKLA AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1) Arteriosclerotic heart disease Interval BETWEEN ONSET AND DEATH Several Months 2) Left hemiplegia (about) 3 mos. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 420.0 DUE TO (c)							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
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)					
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 8-25-59 to 12-19-59 and last saw her/him alive on 12-19-59 . Death occurred at Missouri Baptist Hosp on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Harold Smith M.D.</i> (Degree or title)				22b. ADDRESS 933 Arcade Bldg. 812 Olive St. St. Louis, Mo		22c. DATE SIGNED 12/21/59 (Date)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12/22/59	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City, town, or county) ST LOUIS MISSOURI			
24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE			25. DATE RECD. BY LOCAL REG. DEC 21 1959		26. REGISTRAR'S SIGNATURE <i>Harold Smith M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Handwritten notes:
1-9-61
1-13-61
1-17-61

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 *m w Ruster*

Licensed Embalmer No. 4865
P. O. Address St Louis

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.