

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS JAN 15 1960

'59 0 4 5 9 2 1
 STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **211953**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>	Length of stay in 1b <u>38 YRS</u>	c. CITY OR TOWN <u>ST. LOUIS</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ALEXIAN - BROS - HOSP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2901-RAUSCHENBACH - AV.</u>

3. NAME OF DECEASED (Type or print) First Middle Last <u>EUGENE SCHRADER</u>			4. DATE OF DEATH Month Day Year <u>DEC. 23RD 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>7-22-1891</u>	9. AGE (last birthday) <u>68 YRS</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAREHOUSE - MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHAMPAIN - HOSPITAL SUPPLY - CO.</u>	11. BIRTHPLACE (City and state or country) <u>NEW-YORK-CY. - N.Y.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u><UNKNOWN> SCHRADER</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>VERONICA - SCHRADER <DECD.></u>		

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>486-16-1401</u>	17. INFORMANT <u>FRANK - SCHRADER - 1938 - WRIGHT - ST</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, the Aortic Ring is calcified particularly the valves and pleurisy with effusion</u>		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)
PART II. OTHER SIGNIFICANT disease condition given in PART I (a) <u>Chronic Bronchitis</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

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.) <u>420.1</u>
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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 _____ to _____ and last saw her/him alive on _____.
 Death occurred at 10:45 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paul J. Simon</u> (Degree & title) <u>Deputy Coroner</u>		22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>12/24/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>DEC. 28 - 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY - CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>
24. FUNERAL DIRECTOR <u>Brockland Und. Co. 1827 - HOGAN - ST.</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 24 1959</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

m82

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 J. W. M. Dinsley
Licensed Embalmer No. _____
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.

CEC