

UNITED STATES DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 9 2 7

FILED VS. JAN - 4 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2-11241 STATE FILE NUMBER

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 Saint Louis		Length of stay in 1b Life	c. CITY OR TOWN Saint 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 Deaconess Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5200 S. Broadway Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Louis Middle A. Last Schulte			4. DATE OF DEATH Month Dec. Day 2 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 3/7/77	9. AGE (last birthday) 82 years	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Tool and Die Maker	11. BIRTHPLACE (City and state or country) Saint Louis, Missouri	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Frank Schulte		13b. MOTHER'S MAIDEN NAME Johanna Baack		14. NAME OF HUSBAND OR WIFE Late Emilie Struss Schulte		
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. 488-01-3989a	17. INFORMANT Address Mr. Walter L. Schulte, 449 Foreston Place			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis Pneumonia		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) _____		002x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Malnutrition, dehydration, anemia		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 11/21/59 to 12/2/59 and last saw ^{them} him alive on 12/1/59 Death occurred at 4:15A on the date stated above, and to the best of my knowledge, from the causes stated.						

22a. SIGNATURE (Degree or title) Robert H. Ramsey, M.D.		22b. ADDRESS 25a S. Flouissant, Ferguson Mo		22c. DATE SIGNED 12/16/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-4-59	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Mo.		
24. FUNERAL DIRECTOR ADDRESS CALVIN F. FEUTZ, 4828 NAT'L. BRIDGE BLVD.		25. DATE RECD. BY LOCAL REG. 12-4-1959	26. REGISTRAR'S SIGNATURE Loal Smith M.D.		

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 C. Linden

Licensed Embalmer No. 4275

P. O. Address M. L. Loris,

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.