

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 6 2 4 6

FILED MS JAN - 4 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3485

ENDED

| | | | |
|---|------------------|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY | <u>ST. Louis</u> | a. STATE | <u>Missouri</u> b. COUNTY <u>ST. Louis</u> |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | <u>Kirkwood</u> | c. CITY OR TOWN | <u>Sappington</u> |
| Length of stay in 1b | | Inside Limits | |
| <u>HRS:</u> | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | d. STREET ADDRESS (If outside, give location) | |
| <u>ST. Joseph Hospital</u> | | <u>9100 Birch tree lane</u> | |
| Inside Limits | | Reside on Farm | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

| | | | | | | | |
|--|------------------|--|---------------------------|--|---|-----------------------------|--|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | | | |
| First | Middle | Last | Month | Day | Year | | |
| <u>Carl</u> | <u>D.</u> | <u>Schulze</u> | <u>Dec.</u> | <u>22</u> | <u>1959</u> | | |
| 5. SEX | 6. COLOR OR RACE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HR | |
| <u>Male</u> | <u>White</u> | | <u>Apr. 13, 1902</u> | <u>57</u> | Months | Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) | | 12. CITIZEN OF WHAT COUNTRY | |
| <u>Salesman</u> | | <u>Big 4 Chevrolet</u> | | <u>GERMANY</u> | | <u>U.S.A.</u> | |
| 13a. FATHER'S NAME | | | 13b. MOTHER'S MAIDEN NAME | | 14. NAME OF HUSBAND OR WIFE | | |
| <u>Carl Schulze</u> | | | <u>Marie Wehmeyer</u> | | <u>Matilda Schulze</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | |
| <u>No</u> | | | <u>492-10-4379</u> | | <u>Matilda Schulze 9100 Birch Tree Lane</u> | | |

| | | | |
|---|--|---|--------------|
| 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>Coronary Thrombosis</u> | | <u>5 HRS</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Cardiovascular disease</u> | | |
| | DUE TO (c) <u>Hypertension</u> | | |
| 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 | 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 JAN 1959 to Dec 1989 and last saw her alive on Dec 17 1959
 Death occurred at 9:30 pm Dec 22 1959 m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | | |
|---|----------------------|------------------------------------|--|------------------|
| 22a. SIGNATURE (Degree or title) | | 22b. ADDRESS | | 22c. DATE SIGNED |
| <u>Thomas A. Schuler MD</u> | | <u>20005 Bldway</u> | | <u>12/23/59</u> |
| 23a. FUNERAL CREMATION | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, county) (State) | |
| <u>Funeral</u> | <u>Dec. 26, 1959</u> | <u>Sunset Burial Park</u> | <u>ST. Louis, Co. Mo.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS | | 25. DATE RECD. BY LOCAL REG. | 26. REGISTRAR'S SIGNATURE | |
| <u>Will Bwa. P. U. C. 2929 S. Jefferson</u> | | <u>12-23-59</u> | <u>John B. Murphy MD</u> | |

(Licensed Embalmer's Statement on Reverse Side)

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 Lawrence M. Billo

Licensed Embalmer No. 4375

P. O. Address St. Louis, 23

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.