URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS MAR 7 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1768 STATE FILE NUMBER 60-008833

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis
Length of stay in 1b: 79 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Missouri Pacific Hospital
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St.Louis
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1917 Alfred Ave.
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Julius Middle H. Last Schmitt
4. DATE OF DEATH: Month February Day 14, Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 7/8/1880
9. AGE (last birthday): 79
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): Funeral Director
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St.Louis,Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Philip A.Schmitt
13b. MOTHER'S MAIDEN NAME: Elizabeth Menges
14. NAME OF HUSBAND OR WIFE: Florence
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 486-22-2115
17. INFORMANT: Florence C.Schmitt, Address: 1917 Alfred Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Fractured Left Hip.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 904.0 21
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]
20a. ACCIDENT [X] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Suffered when deceased
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 11 24 59 fell in Home on Nov. 24 1959
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home
20f. CITY, TOWN, OR LOCATION St Louis COUNTY STATE Mo
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at 425A m on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE (Degree or title): Patrick J. Taylor Coroner
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 2.15.6.
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-16-60
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis,Mo.
24. FUNERAL DIRECTOR: Albert H.Hoppe,Inc., ADDRESS: 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: FEB 15 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Geo W Wilkinson

Licensed Embalmer No. 3579

P. O. Address St Louis

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