

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS FEB 18 1960

~~MISSOURI~~

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-1325-60-008843** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3866 Flora Place</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3866 Flora Place</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DR. W.</b> Middle <b>LOUIS</b> Last <b>SCHUCHAT</b>				4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1960</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/2/75</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Moritz Henry Schuchat</b>			13b. MOTHER'S MAIDEN NAME <b>Helene Wieder</b>			14. NAME OF HUSBAND OR WIFE <b>*****</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT Address <b>Mrs. Ben L. Goldberg-3866 Flora Pl.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extracranial Hemorrhage</b> DUE TO (b) <b>Cerebral Sclerosis</b> DUE TO (c) <b>331X</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 <b>1951</b> to <b>Feb. 4 '60</b> and last saw him alive on <b>about Jan. 15, 60</b> Death occurred at <b>4:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <b>Wm B Kountz MD</b>					22b. ADDRESS <b>4500 Olive Street</b>			22c. DATE SIGNED <b>2/4/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2/5/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Sinai Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Herman Rindskopf, Inc. 5216 Delmar</b>				25. DATE RECD. BY LOCAL REG. <b>FEB 4 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <i>ms</i>				

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 *Robert Duboulet*

Licensed Embalmer No. 369

P. O. Address S. H. Anderson

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.