

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 30 1960

60-013571

INDEXED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 947 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Length of stay in 1b <u>3 wks</u>	c. CITY OR TOWN <u>LEMAV</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST Louis County Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>843 ERSKINE AVE.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Adela</u> Middle <u>Schaad</u> Last <u>Schaad</u>	4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>60</u>
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5. SEX <u>FEMALE</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>OCT 7 1899</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>GERALD MO</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>WILLIAM NOECKER</u>	13b. MOTHER'S MAIDEN NAME <u>LYDIA HELLING</u>	14. NAME OF HUSBAND OR WIFE <u>HARRY SCHAAD</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>JOHANNA DOLLARD</u> Address <u>3857 FAIRVIEW A 2 8310</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Myxedema</u>	
	DUE TO (c)	

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>
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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
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21. I attended the deceased from 2-24-60 to 3-18-60 and last saw her him alive on 3-18-60
Death occurred at 12:10 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Morris Gordon MD</u>	22b. ADDRESS <u>601 So. Brentwood</u>	22c. DATE SIGNED <u>3/18/60</u>
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23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-21-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKEWOOD BURIAL Park</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO., MO.</u>
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24. FUNERAL DIRECTOR <u>Fey FUNERAL HOME</u> ADDRESS <u>4100 LA May FERRY</u>	25. DATE RECD. BY LOCAL REG. <u>3-20-60</u>	26. REGISTRAR'S SIGNATURE <u>J. B. Murphy M.D.</u>
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.