

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 30 1960

60-013763

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 690

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Moline</u>	Length of stay in 1b <u>Years</u>	c. CITY OR TOWN <u>Moline</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2326 Chambers Road</u>		d. STREET ADDRESS (If outside, give location) <u>2326 Chambers Road</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Dr. Clara</u> Middle <u>Silver</u> Last <u>Schindler</u>			4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-1894</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chiropractic</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Depp</u>		14. NAME OF HUSBAND OR WIFE <u>Mr. Joseph Schindler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Mr Joseph Schindler, 2326 Chambers Rd.</u>		

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>Acute Coronary Occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15-30 min</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arrhythmia Tachycardia</u>	DUE TO (c) <u>Chronic Myocarditis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) <u>Hypertension Atherosclerosis</u>				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	

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 <u> </u> a.m. <u> </u> p.m. <u> </u>	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 <u>2/21/1957</u> to <u>Feb-27</u> and last saw her <u>him</u> alive on <u>2/25/60</u> Death occurred at <u>1 PM 2/27/60</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22. SIGNATURE (Degree or title) <u>David L. Legler D.O.</u>		22b. ADDRESS <u>5738 W. Flourens</u>		22c. DATE SIGNED <u>2/24/60</u>
23a. NAME OF CEMETERY OR CREMATORY <u>Friedens Cemetery</u>	23b. DATE <u>3-1-1960</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>	(State)
24. FUNERAL DIRECTOR <u>Math. Hermann & Son Inc, 2161 E. Fair.</u>		25. DATE RECD. BY LOCAL REG. <u>3-1-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

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 Welford & Burnley

Licensed Embalmer No. 4202

P. O. Address St Louis

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.