

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017311

FILED VS. MAY 6 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 4412** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR ST. LOUIS CITY HOSP.#1		d. STREET ADDRESS (If outside, give location) 3535 Iowa Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last BERTHA SCHMITT			4. DATE OF DEATH Month Day Year APRIL 22 1960		
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5. SEX Female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-24-1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Indiana	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME Peter Greenwood	13b. MOTHER'S MAIDEN NAME Elizabeth McCoy	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Nina Pearl Claunch	Address 3535^a Iowa
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Pulmonary Edema		
DUE TO (b) Overhydration		
DUE TO (c) 4344		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not deleted to the terminal entry in PART I (a) **Renal Failure, Overhydration, Necrotic Bone 2° senesced, Left Bundle Branch Block**

PART III. If deceased was female was there a pregnancy in last 90 days. Yes N. Unknown

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 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
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21. I attended the deceased from 4-19-60 to 4-22-60 and last saw her/him alive on 4-22-60 Death occurred at 2:55 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Samuel W. Hardy, M.D.	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 4/22/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-25-1960	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens	23d. LOCATION (City, town, or county) (State) St Louis Co Mo
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24. FUNERAL DIRECTOR Thomas Kutis	ADDRESS 2906 Gravois	25. DATE RECD. BY LOCAL REG. APR 25 1960	26. REGISTRAR'S SIGNATURE Neal Smith, M.D.
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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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Gra

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