

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017316

FILED VS. MAY 13 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 4595**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Mo				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			Length of stay in 1b 3-days		c. CITY OR TOWN Jennings Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6333 Emma Ave			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HENRY Middle T. Last SCHOTTMUELLER				4. DATE OF DEATH Month 4 Day 29 Year 60				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1876	9. AGE (last birthday) 83	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) Aluminum Co of America			10b. KIND OF BUSINESS OR INDUSTRY St Louis Mo		11. BIRTHPLACE (City and state or country) U.S.A.		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME Lucas Schottmueller			13b. MOTHER'S MAIDEN NAME Louise Gobel		14. NAME OF HUSBAND OR WIFE Margaret M.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT Address Margaret Schottmueller 6332 Emma Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Carcinomatosis DUE TO (b) Prostat. Carcinoma DUE TO (c) 177X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2 3/4 6 mo	
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"/> No <input type="checkbox"/> 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.)						
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____								
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 1/23/60 to 4/28/60 and last saw her alive on 4/26/60 Death occurred at E a.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) L. Porter M.D.				22b. ADDRESS 205 Princeton		22c. DATE SIGNED 4/29/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 2, 1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St Louis		23e. (State) Mo		
24. FUNERAL DIRECTOR ADDRESS Arthur J. Donnelly 3840 Lindell Blvd.				25. DATE RECD. BY LOCAL REG. APR 30 1960		26. REGISTRAR'S SIGNATURE Neal Smith, M.D.		

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 *W. M. Sargent*
Licensed Embalmer No. 4699
P. O. Address 3840 Finch

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