

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-021484

FILED VS JUN 15 1960

318

1003

5797

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

UNDECEASED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Missouri b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 51 days		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis-Lettle Rock Hospitals, Inc.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4963 Robert		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First John Middle - Last Schimmer				4. DATE OF DEATH Month June Day 4 Year 1960									
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 6-22-1890		9. AGE (last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pensioned Carman				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and state or country) Austria Hungary		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME John Schimmer				13b. MOTHER'S MAIDEN NAME Katharina-----				14. NAME OF HUSBAND OR WIFE Wife- Theresa					
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. 702- 12- 4995		17. INFORMANT Address Theresa Schimmer, 4963 Robert							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Pulmonary Emphysema													
DUE TO (c) Selility										527.1			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis										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 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 Apr. 14, 1960 to 6/4/60 and last saw ^{her} him alive on June 3, 1960 Death occurred at 3.05 A. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Ann Bayl</i> (Degree or title) M.D.				22b. ADDRESS 1755 S. Grand Blvd				22c. DATE SIGNED 6-4-60					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/7/60		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul			23d. LOCATION (City, town, or county) St. Louis, Mo.			(State)			
24. FUNERAL DIRECTOR John L Ziegenhein & Sons ADDRESS 7007 Gravois				25. DATE RECD. BY LOCAL REG. JUN 6 1960		26. REGISTRAR'S SIGNATURE <i>Loal Smith, M.D.</i>							

(Licensed Embalmer's Statement on Reverse Side)

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 G. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Hraw

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.