

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021815

ED VS MAY 3 1 1966

317

Primary Registration District No.

541

Registrar's No.

1312

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>D.O.A</u>		c. CITY OR TOWN <u>MEHLVILLE</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>ST LOUIS COUNTY HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RT 9 - Box 648</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>PHILIP</u> Last <u>SCHUELY</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>16</u> Year <u>1960</u>				
5. SEX <u>MALE</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>JULY-14-1886</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>2</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUTCHER</u>		11. BIRTHPLACE (City and state or country) <u>PEORIA, ILL</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>KARL SCHUELY</u>			13b. MOTHER'S MAIDEN NAME <u>LINKOWN</u>		14. NAME OF HUSBAND OR WIFE <u>OTILLIE SCHUELY</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>492-05-4110</u>		17. INFORMANT <u>OTILLIE SCHUELY</u>		Address <u>RT 9 - Box 648 FAUMGARDNER, 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>Angina</u> DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
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 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 checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Mehlville St Louis County Mo</u>		20f. CITY, TOWN, OR LOCATION <u>Mehlville St Louis County Mo</u>		COUNTY STATE		
21. I attended the deceased from <u>July 1959</u> to <u>Apr. 16/60</u> and last saw her alive on <u>4/15/60</u> Death occurred at <u>709 Elm</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Orlich Mrs</u> (Degree or title)			22b. ADDRESS <u>Imperial, Mo</u>			22c. DATE SIGNED <u>4/16/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Apr-19-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St TRINITY LUTHERAN Cem</u>		23d. LOCATION (City, town, or county) <u>LEMAU, Mo</u>		(State)		
24. FUNERAL DIRECTOR <u>Fey FUNERAL HOME, MEHLVILLE, Mo</u>		ADDRESS <u>4-21-60</u>		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <u>John E. Murphy Mrs</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 Robert J. Law Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood

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.