

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 27 1960

-60-024980

Registration District No. 31C Primary Registration District No. 1003 Registrar's No. 6186 STATE FILE NUMBER

|   |                              |   |  |  |  |
|---|------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                              |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> COUNTY <u>St. Louis</u> |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>                                 |                              | Length of stay in 1b<br><u>Life</u>   | c. CITY OR TOWN <u>Vinita Park</u>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u>              |                              |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><u>8301a Madison</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>CARRIE</u> Middle <u>Schenkmeier</u> Last <u>SKUY</u>                 |                              |   | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>14</u> Year <u>1960</u>   |  |  |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11/20/1879</u>  | 9. AGE (last birthday)<br><u>80</u>                                    | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>       |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  | 11. BIRTHPLACE (City and state or country)<br><u>St. Louis Mo.</u>   |  | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>  |
| 13a. FATHER'S NAME<br><u>Charles Schenkmeier</u>  |                              | 13b. MOTHER'S MAIDEN NAME<br><u>Caroline Kienle</u>   |  | 14. NAME OF HUSBAND OR WIFE<br><u>Jacob Skuy</u>                       |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> |                              | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT Address<br><u>Mr. Louis Portner 10090 Springwld (24)</u> |  |

|  |   |  |   |
|--|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr</u>                                 |
| DUE TO (b) <u>Generalized arteriosclerosis</u>   |   |  | <u>10 yrs</u>   |
| DUE TO (c) <u>Gastrointestinal hemorrhage (cause?)</u>   |   |  | <u>6 wks</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Cholecystolithiasis</u>  |   |  | 331x  |
| PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |   |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____<br>a.m. _____<br>p.m. _____  | Month, Day, Year  |  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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>6/3/60</u> to <u>6/14/60</u> and last saw him alive on <u>6/14/60</u><br>Death occurred at <u>8:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |   |
| 22a. SIGNATURE<br><u>W. W. [Signature]</u> (Degree or title)   |   | 22b. ADDRESS<br><u>5720 Washington St. Louis 8, MO</u>                                       | 22c. DATE SIGNED<br><u>6/15/60</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  | 23b. DATE<br><u>6/17/60</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lake Charles Cemetery</u>                           | 23d. LOCATION (City, town, or county) (State)<br><u>St. Louis Co., Missouri</u> |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Alexander &amp; Sons 6175 Delmar Blvd.</u>  |   | 25. DATE RECD. BY LOCAL REG.<br><u>JUN 16 1960</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Loan Smith, M.D.</u>                            |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mfb

**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 Jos. E. McCullough

Licensed Embalmer No. 276  
P. O. Address 612 1/2 St

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.