

JRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028776

FILED VS JUL 19 1960

6586

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Length of stay in 1b <u>5 days</u>	c. CITY OR TOWN <u>St. Louis</u> <u>4820</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis-Little Rock Hospitals, Inc.,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>10842 Gravois Ave.,</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	<u>Robert</u>	<u>-</u>	<u>Schoenholz</u>		<u>June</u>	<u>27,</u>	<u>1960</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1885</u>	9. AGE (last birthday) <u>75 yrs.</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired merchant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Goods</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Schoenholz</u>	13b. MOTHER'S MAIDEN NAME <u>Maggie Beckart</u>	14. NAME OF HUSBAND OR WIFE <u>Ella Schoenholz (dec)</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>488-03-0946</u>	17. INFORMANT <u>Viola Schoenholz</u>	Address <u>10842 Gravois</u>
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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) <u>Congestive Heart Failure</u>		<u>48 hrs.</u>
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>		<u>5 yrs.</u>
DUE TO (c) <u>Generalized Arteriosclerosis - Pulmonary</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of femur, intertrochanteric. 4/200F</u>		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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Fell in kitchen at home 6/23/60</u>
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20c. TIME OF INJURY Hour <u>!</u> a.m. <u>6-23-60</u> p.m.	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>Home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY <u>Mo.</u>	STATE <u>Mo.</u>
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21. I attended the deceased from <u>1957</u> to <u>6/27/60</u> and last saw him alive on <u>6/27/60</u> Death occurred at <u>10:10 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>Massao Okamoto M.D.</u>	22b. ADDRESS <u>1755 So. Grand Blvd.,</u>	22c. DATE SIGNED <u>JUN 28 1960</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>6-30-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
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24. FUNERAL DIRECTOR <u>Ortmann Funeral Home:</u>	ADDRESS <u>222 Lackland Rd. St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 28 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

(0-5.)-

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 *Sam Stepanovic*

Licensed Embalmer No. *5086*

P. O. Address _____

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