

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028784

FILED VS. AUG 10 1960

318

Primary Registration District No. **1003**

Registrar's No. _____

6828

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 11 weeks		c. CITY OR TOWN Bellefontaine Ngbrs.		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. Johns Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 937 Fontaine Pl.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OTTO Middle F Last SCHULZKE			4. DATE OF DEATH Month July Day 6 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 10/16/1888	9. AGE (last birthday) 71 years	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor			10b. KIND OF BUSINESS OR INDUSTRY Cement		11. BIRTHPLACE (City and state or country) Springfield, Illinois	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Wm. F. Schulzke			13b. MOTHER'S MAIDEN NAME Not Known		14. NAME OF HUSBAND OR WIFE Janette Schulzke			
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. 190-09-1159		17. INFORMANT Address Janette Schulzke - 937 Fontaine Pl.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation							INTERVAL BETWEEN ONSET AND DEATH 3 months	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Hypertensive cardiovascular disease		DUE TO (c) 443x				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral 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 4-16-60 to 7-6-60 and last saw ^{her} him alive on 7-6-1960 Death occurred at 2 P. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Erin Bernhardt, M.D.			22b. ADDRESS 18-S. Kingshighway St. Louis			22c. DATE SIGNED 7-7-1960		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE July 8, 1960	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		23d. LOCATION (City, town, or county) St. Louis County Missouri		(State)		
24. FUNERAL DIRECTOR BUCHHOLZ MORTUARY-5967 West Florissant			25. DATE RECD. BY LOCAL REG. JUL 7 1960		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

BP

AUG 16 1960

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 Gustav W. Gierke

Licensed Embalmer No. 4329

P. O. Address St Louis Mo

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.