

FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028991

FILED VS AUG 8 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2213

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>Kirkwood</u>		Length of stay in lb <u>2 weeks</u>	c. CITY OR TOWN <u>Kirkwood</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. Joseph's Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>120 W. Rose Hill</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>B.</u> Last <u>SCHOTTEL</u>			4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-1944</u>	9. AGE (last birthday) <u>15</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Richmond Heights, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Charles J. Schottel</u>		13b. MOTHER'S MAIDEN NAME <u>Isabella Pence</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>486-46-0127</u>		17. INFORMANT <u>Kirkwood 22</u> Address <u>Mo.</u> <u>Chas. J. Schottel-120 W. Rose Hill</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>Brain Abscess</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Alpha Hemolytic Streptococcus</u>		<u>4 weeks</u>
	DUE TO (c) <u>  </u>		<u>  </u>
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 <u>  </u> / <u>  </u> / <u>  </u>	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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE

21. I attended the deceased from 6/3/60 to 7/23/60 and last saw <sup>her</sup>him alive on 7/23/60  
Death occurred at 7 45 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Charles Burnett M.D.</u>		22b. ADDRESS <u>206 W. Argonne Dr.</u> <u>Kirkwood 22, Mo.</u>		22c. DATE SIGNED <u>7/25/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-26-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>	
24. FUNERAL DIRECTOR <u>Pfzinger Mort-Kirkwood 22, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-25-60</u>	26. REGISTRAR'S SIGNATURE <u>J. B. Murphy M.D.</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 \_\_\_\_\_, Student Embalmer, No. \_\_\_\_\_  
or by \_\_\_\_\_, \_\_\_\_\_, Student Embalmer, No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.