

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-029263**

STATE FILE NUMBER

FILED VS. JUL 22 1960

317

500

2044

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cool Valley (St. Louis Co.)</b> Length of stay in 1b <b>2 yrs.</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hill Top House</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> c. CITY OR TOWN <b>Florissant, Mo.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>8 Valley Drive</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MINNIE E.</b> Middle <b>SCHUERMAN</b> Last _____			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>7</b> Year <b>1960</b>		
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10-8-1885</b>	<b>9. AGE</b> (last birthday) <b>74</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HR</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>xx</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Chicago, Ill.</b>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>		<b>13a. FATHER'S NAME</b> <b>Gustave Spanhake</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	
<b>14. NAME OF HUSBAND OR WIFE</b> <b>Deceased</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>Wm. H. Schuermann, Florissant, Mo.</b> Address <b>8 Valley Dr.,</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) <b>Senile Dementia</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b> _____ <b>STATE</b> _____	
<b>21. I attended the deceased from</b> <b>June 1, 1958</b> <b>to</b> <b>July 7, 1960</b> <b>and last saw her</b> <b>alive on</b> <b>July 7, 1960</b> <b>Death occurred at</b> <b>6:30 P.M.</b> <b>on the date stated above, and to the best of my knowledge, from the causes stated.</b>					
<b>22a. SIGNATURE</b> (Degree or title) <b>John G. McInerney MD</b>			<b>22b. ADDRESS</b> <b>5014 Thekla Av</b>		<b>22c. DATE SIGNED</b> <b>7/7/60</b>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>		<b>23b. DATE</b> <b>7-8-60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Ridge Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Broadview, Ill. (Cook Co.)</b>
<b>24. FUNERAL DIRECTOR</b> <b>The Florissant Mortuary, Florissant, Mo.</b> ADDRESS _____			<b>25. DATE RECD. BY LOCAL REG.</b> <b>7-7-60</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>John G. McInerney</i>

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 *Gene A. Sutchins*

Licensed Embalmer No. 4966

P. O. Address Florissant, 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.