

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033134

FILED VS SEP 7 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 2350

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cole		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN University City		Length of stay in 1b	c. CITY OR TOWN Jefferson City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8423 Gannon		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 311 Miller St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mollie Middle Mabel Last Schultz			4. DATE OF DEATH Month August Day 6 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-19-1886	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Stafford, Kansas		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME George R. Cruzen		13b. MOTHER'S MAIDEN NAME LUCINDA Unknown Elder		14. NAME OF HUSBAND OR WIFE Carl F. Schultz	
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. No		17. INFORMANT Richard D. Schultz, 8423 Gannon	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Dis. DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 2 hrs 5-10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Bronchitis; Pulmonary Emphysema				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	
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 Month, Day, Year s.m. p.m.					
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 (see over) to (see over) and last saw her alive on 8/6/60 Death occurred at 12:10 AM on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) R. W. Kelley M.D.			22b. ADDRESS 2720 Washington St. St. Louis 8, Mo		22c. DATE SIGNED 8/6/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-6-1960	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Jefferson City, Missouri
24. FUNERAL DIRECTOR C. R. Lupton & Sons, St. Louis, Mo.			25. DATE RECD. BY LOCAL REG. 8-6-60		26. REGISTRAR'S SIGNATURE [Signature]

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Deceased a patient of Dr. J. C. Edwards (St. Louis)
was seen by undersigned in Dr. Edwards
absence on vacation. Diagnosis had
been established in two admissions
to the St. Lukes Hospital (Feb 1958
and July 1960). ~~He~~ Deceased had
been under care and observation
of Dr. Edwards since Feb. 1958
A. Schoen
M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arnold W. Schoen

Licensed Embalmer No. 386

P. O. Address St. Louis

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