

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 St. Louis		Length of stay in lb 2 weeks	c. CITY OR TOWN Chesterfield
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Clayton Rd.

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First	Middle	Last	Month	Day
Gustav Schupmann			Nov	24
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 2-14-90	9. AGE (last birthday) 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) minister		10b. KIND OF BUSINESS OR INDUSTRY Trinity Church	11. BIRTHPLACE (City and state or country) Appleton, Texas	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Albert Schupmann		13b. MOTHER'S MAIDEN NAME Bertha Martinsen		14. NAME OF HUSBAND OR WIFE Maria Schupmann
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 Address Maria Schupmann, Chesterfield Mo	

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)	Myocardial infarction	2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Coronary occlusion	
	DUE TO (c) 4201	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pneumonia		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 Nov. 10, 1960 to Nov. 24, 1960 and last saw him alive on Nov. 24, 1960 Death occurred at St. Louis 1:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE George E. Smith, M.D.	(Degree or title)	22b. ADDRESS 325 N. Kirkwood Road Kirkwood 22, Mo.	22c. DATE SIGNED 11/25/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-28-60	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	23d. LOCATION (City, town, or county) St. Louis Co., Mo.
24. FUNERAL DIRECTOR Schrader Funeral Home	ADDRESS Ballwin, Mo.	25. DATE RECD. BY LOCAL REG. 11/26/60	26. REGISTRAR'S SIGNATURE Georg Smith, M.D.

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 Richard Bopp

Licensed Embalmer No. 4584

P. O. Address Ballwin

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.