RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-044761

ILED VS DEC 1 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3310

NDED

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN — Length of stay in 1b: 3 months
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Vista Bella — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 956 Canaan Ave — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle F Last SCHADER

4. DATE OF DEATH: Month November Day 11 Year 1960

5. SEX: male
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1/9/1890
9. AGE (last birthday): 70 years — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: ——
11. BIRTHPLACE (City and state or country): Illinois
12. CITIZEN OF WHAT COUNTRY: U. S. A.

13a. FATHER'S NAME: Wendell Schader
13b. MOTHER'S MAIDEN NAME: Margaret Wetzel
14. NAME OF HUSBAND OR WIFE: Mayme K. Schader

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.: unk.
17. INFORMANT Address: Mayme Schader - 956 Canaan Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Infected Decubitus Ulcers — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Senile Degeneration, CNS — many years
DUE TO (c) Lues and Recurrent Pneumonia

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Oct 1960, to Nov 11, 60 and last saw her/him alive on 11/11/60
Death occurred at 930 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Charles K Holbrook MD
22b. ADDRESS: 9901 Diamond Dr.
22c. DATE SIGNED: NOV 10 1960

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: Nov.15,1960
23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County Missouri

24. FUNERAL DIRECTOR ADDRESS: BUCHHOLZ MORTUARY-5967 W.Florissant Ave.
25. DATE RECD. BY LOCAL REG.: 11-14-60
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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_____ Signed Wilfred F Buchl

Signature of Student Embalmer

Licensed Embalmer No. 4557

P. O. Address St Louis

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