

VS DEC 21 1960

-60-047898

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

11953

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Incarinate Wd. H osp</u>		d. STREET ADDRESS (If outside, give location) <u>3836 Shenandoah</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>L.</u> Last <u>Schmidkonz</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1960</u>		
---	--	--	--	--	--

5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married: <input type="checkbox"/> Never Married: <input type="checkbox"/> Widowed: <input checked="" type="checkbox"/> Divorced: <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 1, 1890</u>	9. AGE (last birthday) <u>70</u>	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) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	--	--	---

13a. FATHER'S NAME <u>James Williams</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Archambolt</u>	14. NAME OF HUSBAND OR WIFE <u>Andrew Schmidkonz</u>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>	16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT <u>Elizabeth Williams</u>	Address <u>3836 Shenandoah</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>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-2-60</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (a) <u>Cardio Renal Vascular disease</u>		<u>present 11-7-60</u>
DUE TO (b) <u>Gangrene both feet</u>		<u>12-4-60</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Popelary adenocarcinoma & prostate</u>		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 checked="" type="checkbox"/> NO <input 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.) <u>442XH</u>
---	---	--

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 <u>11-7-60</u> to <u>12-11-60</u> and last saw her alive on <u>12-10-60</u> Death occurred at <u>630 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>John M. Dunn MD</u> (Degree or title)	22b. ADDRESS <u>1715 So 39th St Jansky</u>	22c. DATE SIGNED <u>12-12-60</u>
--	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>12-14-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Jeff. Brks., Mo.</u>
---	------------------------------	--	--

24. FUNERAL DIRECTOR <u>Southern Funeral Home</u> 6322 S. Grand, St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. <u>DEC 13 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith, M.D.</u>
---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr Flynn
1715 & 39th
Nov 3 ³⁰ PM

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

David Van Fossen

Licensed Embalmer No. 4242

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.