

DATE AMENDED
 AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF DECEASED (If not in hospital, give location) St. Louis, Little Rock Hospitals, Inc.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3240 Lafayette Ave.

3. NAME OF DECEASED (Type or print) First Middle Last George Schuh, Jr.	4. DATE OF DEATH Month Day Year April 23, 1961
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5. SEX Male	6. COLOR OR RACE White	7. XXXXXXXXXXXX Divorced	8. DATE OF BIRTH 7/15/03	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Palestine Texas	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME George Schuh	13b. MOTHER'S MAIDEN NAME Elizabeth Newberger	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 2	17. INFORMANT Address William Schuuh 3930 Villanova Texas
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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) Acute Cardiac Failure		Few hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Heart Disease	Same 1 Month
	DUE TO (c) 4200	

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input 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.)
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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
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21. I attended the deceased from **April 19, 1961** to **April 23, 1961** and last saw ~~him~~ ^{her} alive on **April 22, 1961**
 Death occurred at **11:00 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Benjamin H. Charles, Jr. - M.D.	22b. ADDRESS 1755 So. Grand Ave.	22c. DATE SIGNED Apr. 24, 1961
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Apr 26, 61	23c. NAME OF CEMETERY OR CREMATORY East Hill	23d. LOCATION (City, town, or county) (State) Palestine Texas
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24. FUNERAL DIRECTOR ADDRESS Bailey Funeral Home - Palestine, Texas E. J. Schnur 3125 Lafayette	25. DATE RECD. BY LOCAL REG. APR 26 1961	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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20 N. 10th Street, S.W.

Atlanta, Georgia

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STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed John Hollimer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.