

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035457

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2730 STATE FILE NUMBER

AMENDED

FILED OCT 9 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MEHLVILLE</u>		Length of stay in 1b <u>2 WKS.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RT 9 - BOX 653 BAUMGARTNER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OTTILIE LOUISE SCHULEY</u>		4. DATE OF DEATH Month Day Year <u>SEPT - 23 - 1961</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>8-16-1892</u>
9. AGE (last birthday) <u>69</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>1 7</u>	
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>HOME</u>	
11. BIRTHPLACE (City and state of country) <u>HANNIBAL MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>PETER KROECK</u>		13b. MOTHER'S MAIDEN NAME <u>OTTILIE TULLUS</u>	
14. NAME OF HUSBAND OR WIFE (Deceased) <u>CHARLES SCHULEY</u>		Address <u>RT-9-Box 653 MEHLVILLE 29 Mo.</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>		16. SOCIAL SECURITY NO. <u>NIL</u>	
17. INFORMANT <u>WALTER KROECK</u>		Address <u>RT-9-Box 653 MEHLVILLE 29 Mo.</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>Coronary a. Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 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 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>Sept. 4, 1961</u> to <u>Sept. 22, 1961</u> and last saw her <u>live</u> on <u>Sept 22, 1961</u> Death occurred at <u>home</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Walter Kroeck</u> (Degree or title) <u>D.C.</u>		22b. ADDRESS <u>631 Union St. Cotton 100</u>	22c. DATE SIGNED <u>9/25/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT 26 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>KEMAY MO</u>
24. FUNERAL DIRECTOR <u>Fey Funeral Home, MEHLVILLE MO</u>		25. DATE RECD. BY LOCAL REG. <u>9-27-61</u>	26. REGISTRAR'S SIGNATURE <u>John G. Murphy M.D.</u>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 *Gustav W. Dite*

Licensed Embalmer No. 4329

P. O. Address St Louis Mo

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.