

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-71-039175
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10107

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN d. STREET ADDRESS (If outside, give location)	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Length of stay in lb 9 Days	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane Hospital		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		(If outside, give location) 3620 Clarence Ave.	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Amelie (aka Millie) Reitz Schaefer			4. DATE OF DEATH Month Day Year 10 28 1961
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/5/89
9. AGE (last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Frederick Reitz		13b. MOTHER'S MAIDEN NAME Amelia Seele	14. NAME OF HUSBAND OR WIFE Andrew L. Schaeffer
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. None	17. INFORMANT Address Mr. Russell J. Schaefer Overbrook 17
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Interus Gravis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <i>non visualized gallbladder</i> DUE TO (b) <i>inoperable</i> DUE TO (c) <i>non reparable, coronary occlusion</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <i>non-functioning gall-bladder</i>			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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>none</i>	
20c. TIME OF INJURY Hour Month, Day, Year <i>none</i>		20d. PLACE OF INJURY (e.g., in or about home; farm, factory, street, office bldg., etc.) <i>none</i>	
20e. CITY, TOWN, OR LOCATION COUNTY STATE		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>Sept 2 1961</i> to <i>10-28-61</i> and last saw her alive on <i>10 am</i> Death occurred at <i>11:45 am 10-28-61</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE M. F. Harmann (Degree or title) <i>M. F. Harmann MD</i>		22b. ADDRESS 2739 Grand St St. Louis, Mo.	22c. DATE SIGNED 10-28-61
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 11-1-61	23c. NAME OF CEMETERY OR CREMATORY Valhalla Mausoleum	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR ADDRESS Drehmann-Harral, 1905 Union Blvd.		25. DATE RECD. BY LOCAL REG. OCT 31 1961	26. REGISTRAR'S SIGNATURE Loan 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address _____

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.