SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED NOV 28 1961

-61-042873
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10533

DATE AMENDED

ITEM NO. SHOULD READ INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST LOUIS
Length of stay in 1b: 16 DAYS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: LUTHERN HOSPITAL
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI
b. COUNTY: ST LOUIS
c. CITY OR TOWN: MEHLVILLE
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): RT 9-BOX 608
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First HENRY Middle P. Last SCHUETZ
4. DATE OF DEATH: Month NOV Day 11 Year 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: APR-3-1894
9. AGE (last birthday): 67
IF UNDER 1 YEAR: Months 7 Days 8
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED - FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (City and state or country): ST LOUIS CO MO
12. CITIZEN OF WHAT COUNTRY: U.S.A
13a. FATHER'S NAME: HENRY SCHUETZ
13b. MOTHER'S MAIDEN NAME: ANNIE ROTT
14. NAME OF ~~HUSBAND OR~~ WIFE: KATIE SCHUETZ DECEASED
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NIL
16. SOCIAL SECURITY NO.:
17. INFORMANT: MILDRED NIEMEIER Address: RT 9-BOX 613 MEHLVILLE 29 MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
INTERVAL BETWEEN ONSET AND DEATH: 24 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 491X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Hypertensive Encephalopathy
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 1/13/58 to 11/11/61 and last saw him live on 11/11/61
Death occurred at 3:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Edward U. Gebhardt M.D.
22b. ADDRESS: 3701 Crawford Sq
22c. DATE SIGNED: 11/13/61

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: NOV-14-1961
23c. NAME OF CEMETERY OR CREMATORY: OLD ST JOHNS CEM.
23d. LOCATION (City, town, or county) (State): MEHLVILLE MO
24. FUNERAL DIRECTOR ADDRESS: FEY FUNERAL HOME MEHLVILLE
25. DATE RECD. BY LOCAL REG.: MO NOV 13 1961
26. REGISTRAR'S SIGNATURE: Boad Smith M.D.

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 _____ Signed Gustav W Dieter

Signature of Student Embalmer

Licensed Embalmer No. 4329

P. O. Address St Louis

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.