

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

Primary Registration District No.

1003

Registrar's No.

272

62-004494
STATE FILE NUMBER

AMENDED

Registration District No.

FILED JAN 11 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
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 Bethesda Hospital		d. STREET ADDRESS (If outside, give location) 6574 Scanlan Ave.	
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 AUGUSTA Middle B. Last SCHROEDER			4. DATE OF DEATH Month Jan. Day 6 Year 1962			
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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 9-8-1885	9. AGE (last birthday) 76	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) Housework	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Genevieve, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Peter Fallor	13b. MOTHER'S MAIDEN NAME Catherine Rehm	14. NAME OF HUSBAND OR WIFE Late Oscar D. Schroeder
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Audrey Wilson 6574 Scanlan Ave.	Address
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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) Atrial Fibrillation		1 month
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Heart disease	2 years
	DUE TO (c) Generalized Arteriosclerosis	2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease (condition given in PART I (a)) Gastro-enteritis, chronic cholecystitis, Pleural Effusion, Edema of legs, Thrombophlebitis of leg.		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
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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.) 4200
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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 Oct 7, 1961 to Jan 6, 1962 and last saw her Jan 6, 1962 alive on Jan 6, 1962 Death occurred at 2:30 P. on the date stated above, and to the best of my knowledge, from the causes stated.	
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21. SIGNATURE (Degree or title) Geroy E. Ellison M.D.	22b. ADDRESS 3610 Le Boulevard St Louis Mo	22c. DATE SIGNED Jan 8/1962
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Jan. 10, 1962	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.	25. DATE RECD. BY LOCAL REG. JAN 8 1962	26. REGISTRAR'S SIGNATURE Loan Smith M.D.
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AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 William B White

Licensed Embalmer No. 4291

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.