

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009407

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 517

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 23 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy		Length of stay in lb 17 Days	c. CITY OR TOWN Kirkwood
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O'Sullivan Nursing		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1165 S. Glenwood Lane
3. NAME OF DECEASED (Type or print) First Lydia Middle A. Last Schnell		4. DATE OF DEATH Month 2 Day 10 Year 1962	
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 12-24-80
9. AGE (last birthday) 81		IF UNDER 1 YEAR Months _____ Days _____	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 William Honigmann	
13b. MOTHER'S MAIDEN NAME Mathilda -		14. NAME OF HUSBAND OR WIFE John J. Schnell	
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 Elmer H. Schnell, Address 1165 S. Glenwood Lane
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH unknown
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 1-16-62 to 2-10-62 and last saw her ^{him} alive on 2-5-62 Death occurred at 4 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Lewis S. Lutzmann MD (Degree or title)		22b. ADDRESS 8231 Clayton Rd (17)	22c. DATE SIGNED 2/12/62
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 2-13-62	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	23d. LOCATION (City, town, or county) St. Louis County Mo.
24. FUNERAL DIRECTOR Drehmann-Harral, 1905 Union Blvd. ADDRESS		25. DATE RECD. BY LOCAL REG. 2-12-62	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Lewis Littmann
8231 Clayton
Pa 7-0202
Hrs. 2-2

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. 3537

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.