

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED APR 6 1962 318

1003

3212

-62-013156

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

VS 300 Rev. 4/59	DATE AMENDED
1	
2 2147	
3	
4 1	
5 0	
6	
7 2	
8 2	
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10	
11 90-0	
13 90	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

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		Length of stay in 1b 34 yrs.	c. CITY OR TOWN St Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5340 Devonshire		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5340 Devonshire Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Schlette			4. DATE OF DEATH Month Day Year March 23 1962
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1874
9. AGE (last birthday) 87		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) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Germany
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Phillip Schlette	
13b. MOTHER'S MAIDEN NAME Catherine Seibel		14. NAME OF HUSBAND OR WIFE	
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.	17. INFORMANT Helen A Holz Address 5340 Devonshire
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>Cerebro-Vascular Accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>			<u>20 years</u>
DUE TO (c) <u>Bruscardiac Aesthema</u>			<u>?</u>
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. <u>4200</u> <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>March 23 1962</u> to <u>March 23 1962</u> and last saw her <u>alive</u> on <u>March 23, 1962</u> Death occurred at <u>5:00</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Walter Schlette</u> (Degree or title)		22b. ADDRESS <u>4417 W. Alton Ave</u>	22c. DATE SIGNED <u>3/25/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/26/62	23c. NAME OF CEMETERY OR CREMATORY St Paul Churchyard	23d. LOCATION (City, town, or county) (State) St Louis County Mo.
24. FUNERAL DIRECTOR John L Ziegenhein & Sons 7027 Gravois		25. DATE RECD. BY LOCAL REG. MAR 26 1962	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>

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 B. P. Kedwell

Licensed Embalmer No. 3877

P. O. Address 7027 Graves

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.