

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5568-62-020966  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

**FILED JUN 7 1962**

VS 300  
Rev. 4/59

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**2/022-38**

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ...

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>		Length of stay in 1b <b>1 da</b>	c. CITY OR TOWN <b>Ellisville</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Johns</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>527 Clarkson Rd</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ann</b> Last <b>Schroeder</b>			4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/2/1962</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours <b>21</b> Min. _____
11. BIRTHPLACE (City and state or country) <b>St Louis Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Ernest Schroeder</b>		13b. MOTHER'S MAIDEN NAME <b>Claire M Moritz</b>	
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) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ernest Schroeder Ellisville Mo</b> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Atelectasis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>762.5</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>Prematurity</b>			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 checked="" type="checkbox"/> NO <input 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. _____	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 <b>Birth</b> to <b>6-3-62</b> and last saw her <sup>her</sup> <del>live</del> <sup>live</sup> on <b>6-3-62</b> Death occurred at <b>3:45Pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Ortmann F Home</i> (Deedee or title)		22b. ADDRESS <b>634 N. Grand</b>	22c. DATE SIGNED <b>6-4-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6/4/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Monicas Cemetery</b>	23d. LOCATION (City, town, or county) <b>Creve Coeur Mo</b>
24. FUNERAL DIRECTOR <b>Ortmann F Home 9222 Lackland Overland Mo</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 4 1962</b>	26. REGISTRAR'S SIGNATURE <i>Head Smith, M.D.</i>

**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 No Embalming  
James Kester

Licensed Embalmer No. \_\_\_\_\_

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.