

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

482562-020967
STATE FILE NUMBER

318 1003

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED MAY 23 1962

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY		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 ALEXIAN BROS. HOSPITAL				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 535 W. DAVIS				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle SCHROEER Last						4. DATE OF DEATH Month MAY Day 11 Year 1962					
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH APR 16 1898		9. AGE (last birthday) 64		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MISSOURI U-S-A		12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME ALBERT SCHROEER				13b. MOTHER'S MAIDEN NAME CATHERINE SCHMITTEL				14. NAME OF HUSBAND OR WIFE PEARL SCHROEER			
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 Address PEARL SCHROEER 535 W. DAVIS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris										INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 4202											
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 April 15, 1962 to May 11-62 and last saw him alive on 5-5-62 Death occurred at 5/11/62 on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE C. W. Z. [Signature] (Degree or title) M.D.						22b. ADDRESS 1504 So. Grand			22c. DATE SIGNED 5/11/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE MAY 14 1962		23c. NAME OF CEMETERY OR CREMATORY MOUNT HOPE CEMETERY		23d. LOCATION (City, town, or county) ST. LOUIS CO. MO.		(State)			
25. DATE RECD. BY LOCAL REG. MAY 11 1962				26. REGISTRAR'S SIGNATURE Loan Smith, M.D.							
GENERAL DIRECTOR ADDRESS Thomas Kutis 2906 Gravois											

USE BLACK INK OR TYPEWRITER RIBBON

*Dr. Grafton,
Grand Park*

*PA 1-3334
with 2130*

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 *Eleana Province*

Licensed Embalmer No. *3403*

P. O. Address *2906 groves*

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.