

# MISSOURI DIVISION OF HEALTH - STANDARD AFFIDAVIT OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029143

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7150

**FILED JUL 31 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

USE BLACK INK OR TYPEWRITER RIBBON

|  |  |   |                   |   |  |  |  |   |                                    |  |  |
|--|--|---|-------------------|---|--|--|--|---|------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                     |                   | Length of stay in 1b  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |  | c. CITY OR TOWN <b>St. Louis</b>  |                                    | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>  |  |   |                   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  | d. STREET ADDRESS<br><b>5317 Pernod Ave.</b>   |  |   |                                    | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>NORA A. SCHLUETER</b>   |  |   | First Middle Last |   |  | 4. DATE OF DEATH<br><b>July 20 1962</b>  |  |   | Month Day Year                     |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |                   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2-10-1896</b>   |  | 9. AGE (last birthday)<br><b>66</b>   |                                    | IF UNDER 1 Year<br>Months Days Hours Min.                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>  |  |   |                   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |                                    |  |  |
| 13a. FATHER'S NAME<br><b>John T. Henry</b>   |  |   |                   | 13b. MOTHER'S MAIDEN NAME<br><b>Mary A. Leonhardt</b>   |  |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Arthur T. Schlueter</b>   |                                    |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No None</b>  |  |   |                   | 16. SOCIAL SECURITY NO.<br><b>153.8</b>   |  | 17. INFORMANT<br><b>Arthur T. Schlueter 5317 Pernod Ave.</b>   |  |   |                                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b><br>DUE TO (b) <b>Carcinoma of colon</b><br>DUE TO (c) <b>153.8</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |                   |   |  |  |  |   |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b>                        |  |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |                                    |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 <b>Feb. 19, 1962</b> to <b>July 20, 1962</b> and last saw her alive on <b>July 20, 1962</b><br>Death occurred at <b>6:30 A.</b> on the date stated above, and to the best of my knowledge from the causes stated.   |  |   |                   |   |  |  |  |   |                                    |  |  |
| 22a. SIGNATURE <b>C.G. Vournas</b> (Degree or title) <b>M.D.</b>   |  |   |                   |   |  | 22b. ADDRESS<br><b>3720 Washington</b>   |  |   | 22c. DATE SIGNED<br><b>7-20-62</b> |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>July 23, 1962</b>   |                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>   |  | 23d. LOCATION (City, town, or county)<br><b>St. Louis, Mo.</b>   |  | 23e. (State)  |                                    |  |  |
| 24. FUNERAL DIRECTOR<br><b>Kriegshauser 4228 S. Kingshighway Blvd.</b>   |  |   |                   |   |  | 25. REC'D. BY LOCAL REG.<br><b>JUL 20 1962</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Roan Smith, M.D.</b>  |                                    |  |  |

**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.