

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-033272

FILED SEP 4 1962 317

Registration District No. _____ Primary Registration District No. 590 Registrar's No. 2411

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 4039
2 4060

3
4 1
5 2

6
7 0
8 2

9 260X

10

11

12 86-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. John's		Length of stay in 1b 5 Yrs.	c. CITY OR TOWN Marvin Terrace Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rugh Manor Rest Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3631 Marvin Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Anna Middle L Last Schuler			4. DATE OF DEATH Month 8 Day 17 Year 62
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 2-21-1899
9. AGE (last birthday) 62		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) Supply Clerk		10b. KIND OF BUSINESS OR INDUSTRY Hornes Hospit.	11. BIRTHPLACE (City and state or country) St. Louis Co, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Basil Mareschal	
13b. MOTHER'S MAIDEN NAME Emma Teason		14. NAME OF HUSBAND OR WIFE Arthur Schuler Dec.	
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. UNK	17. INFORMANT Joseph Mareschal Address 340 S. Castello Dr.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma DUE TO (b) Diabetes Mellitus Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 12 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arterio-Sclerotic Cardio-Vascular Disease		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"/> NONE	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 June 1961	COUNTY _____ STATE _____
21. I attended the deceased from June 1961 to 8-17-62 and last saw her ^{him} alive on 8-17-62 Death occurred at 5:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Allen M. Kearney M.D.		22b. ADDRESS 860 N. Woodlawn	22c. DATE SIGNED 8-20-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-21-62	23c. NAME OF CEMETERY OR CREMATORY St. Ferdinand, Cemetery	23d. LOCATION (City, town, or county) (State) Florissant, Missouri
24. FUNERAL DIRECTOR J.W. Clark F.H. 1125 Hodiamont Ave.		25. DATE RECD. BY LOCAL REG. 8-20-62	26. REGISTRAR'S SIGNATURE John M. [Signature]

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 *M. W. Wilentz*

Licensed Embalmer No. *4511*
P. O. Address *A. Lavin, Mo.*

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.