

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

MISSOURI DIVISION OF PUBLIC HEALTH AND WELFARE

-62-040717

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **980E**

FILED OCT 19 1962																	
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		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 3029 SHENANDOAH				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3029 SHENANDOAH						Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) RICHARD SCHROEDER						4. DATE OF DEATH OCT. 11 1962			Month			Day			Year		
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 MARCH 29 1908		9. AGE (last birthday) 54		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) DRIVER						10b. KIND OF BUSINESS OR INDUSTRY FALSTAFF BREWERY MO.			12. CITIZEN OF WHAT COUNTRY U.S.A.								
13a. FATHER'S NAME RICHARD SCHROEDER				13b. MOTHER'S MAIDEN NAME NELLIE EVANS				14. NAME OF HUSBAND OR WIFE MARY SCHROEDER									
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 MARY SCHROEDER 3029 SHENANDOAH									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE																	
DUE TO (b) RHEUMATIC HEART DISEASE - AORTIC STENOSIS																	
DUE TO (c) 4/1 X																	
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 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 SEPT 3 1962 to OCT 11 1962 and last saw her/him alive on OCT 10 1962 Death occurred at 6:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE (Degree or title) <i>Marion E. Under M.D.</i>						22b. ADDRESS 4652 MARYLAND ST. ST. LOUIS MO.			22c. DATE SIGNED 10-12-62								
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE OCT. 13 1962		23c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCUS			23d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.										
24. FUNERAL DIRECTOR <i>Thomas Kutek</i>						ADDRESS 2906 Georgia		25. DATE RECD. BY LOCAL REG. OCT 13 1962		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>							

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1
2 **217**
3
4 **0**
5 **1**
6
7 **0**
8 **2**
9
10
11
12 **90-0**
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

90

Mr. Martin Beards

4652 Maryland

FO 7-4057

Dr. Michael Harris
Office

1-4 Friday

RM 100

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 Eleanor Horvitz

Licensed Embalmer No. 3403

P. O. Address 2906 Grand

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.