

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-041249

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 323 Primary Registration District No. 4474 Registrar's No. 62

FILED OCT 16 1962	
1. PLACE OF DEATH	
a. COUNTY <u>SALINE</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sweet Springs</u>	a. STATE <u>Mo</u> b. COUNTY <u>St. Louis Co</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Community Hosp.</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
	d. STREET ADDRESS (If outside, give location) <u>1449 NORMAN PLACE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	
First <u>GARY</u>	Middle <u>bee</u> Last <u>Schmidt</u>
4. DATE OF DEATH <u>Oct. 18 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/1944</u>
9. AGE (last birthday) <u>18 YRS</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>17</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>
11. BIRTHPLACE (City and state or country) <u>St. Louis</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>Dr. Carl H. Schmidt</u>	13b. MOTHER'S MAIDEN NAME <u>Card Antrey</u>
14. NAME OF HUSBAND OR WIFE <u></u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>
17. INFORMANT <u>Dr. Carl H. Schmidt, St. Louis, Mo.</u>	Address <u></u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <u>Skull fracture left Parietal bone</u>	
DUE TO (b) <u>Multiple fractures ribcage</u>	
DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)	
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 SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Hiway 40 - 2 miles East of Andover</u>	
20c. TIME OF INJURY <u>11 a.m.</u> Month, Day, Year <u>10-18-62</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hiway 40</u>
20f. CITY, TOWN, OR LOCATION <u>Saline</u> COUNTY <u>Saline</u> STATE <u>Mo</u>	
21. I attended the deceased from <u>9 am</u> to <u>10-14-62</u> and last saw her/him alive on <u>10-14-62</u> . Death occurred at <u>11 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Dr. Lawrence M.D. Croner Saline Co</u>	22b. ADDRESS <u>Marshall 7718</u>
22c. DATE SIGNED <u>10-14-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10/17/1962</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Mausoleum St Louis</u>	
23d. LOCATION (City, town, or county) <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Dave Miller</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 14, 1962</u>
26. REGISTRAR'S SIGNATURE <u>Marjorie Masley</u>	

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 ITEM NO.

DATE AMENDED
 DOCUMENT
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

OCT 17 1962

Removal Permit Issued 10/14/1962

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 Gene G. Miller

Licensed Embalmer No. 4783

P. O. Sweet Springs, 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.