

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044833

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

11213

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registrar's District No. **1003** Registrar's No. **11213**

FILED NOV 30 1962

VS 300 Rev. 4/59	DATE AMENDED
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF	
DOCUMENT	
MEDICAL CERTIFICATION	
BY AFFIDAVIT OF	

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) ST LOUIS		c. CITY OR TOWN SPRINGFIELD	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FASCO Hosp.		d. STREET ADDRESS (If outside, give location) 1525 W HOUST	
3. NAME OF DECEASED (Type or print) Valentine B. Schmidt		4. DATE OF DEATH NOV 22 1962	
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH About 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (City and state or country) ILLINOIS
13a. FATHER'S NAME JACOB Schmidt		13b. MOTHER'S MAIDEN NAME KEMPF	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Ruby Schmidt Springfield	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS OF CORONARY ARTERY		INTERVAL BETWEEN ONSET AND DEATH 120 DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 332X		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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 JULY 23 1962 to NOV 22 1962 and last saw him alive on NOV 22 1962 Death occurred at 11:20 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul J. Smith MD		22b. ADDRESS FASCO HOSPITAL ST LOUIS MO	
22c. DATE SIGNED 11-22-62			
23a. BURIAL CREMATION REMOVAL (Specify) Removal		23b. DATE 11-24-62	
23c. NAME OF CEMETERY OR CREMATORY Green Lawn		23d. LOCATION (City, town, or county) SPRINGFIELD MO	
24. FUNERAL DIRECTOR Adams-Morgan Funeral Home		25. DATE RECD. BY LOCAL REG. NOV 22 1962	
		26. REGISTRAR'S SIGNATURE Ruby Smith M.D.	

USE BLACK INK OR TYPEWRITER RIBBON

DEC 26 1962

DEC 12 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

James L. Curson

Licensed Embalmer No. 5168

P. O. Address *M. Detroit, MI*

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 the body is not embalmed, fact should be so stated above.