

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048723

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. _____

Registrar's No. **12204**

STATE FILE NUMBER

FILED JAN 2 1962

1. PLACE OF DEATH a. COUNTY _____		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		Length of stay in 1b 65 yrs.	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP #1.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2931a Hebert St.			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First CHARLES Middle J. Last SCHULZ				4. DATE OF DEATH Month DEC. Day 17, Year 1962		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 9-25-97	9. AGE (last birthday) 65	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) parts Dept. Clerk				10b. KIND OF BUSINESS OR INDUSTRY Motor parts		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.							
13a. FATHER'S NAME Charles F. Schulz,				13b. MOTHER'S MAIDEN NAME Agatha Schmid,			14. NAME OF HUSBAND OR WIFE Adele Schulz								
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. None		17. INFORMANT Address Mrs. Adele Schulz, 2931a Hebert									
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Disease - DUE TO (b) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) 4341 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Indolentia, due to psychiatric depression 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										INTERVAL BETWEEN ONSET AND DEATH 8 weeks.					
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 8/29/62 10:40 a to 12/17/62 and last saw her/him alive on 12/17/62 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.										22a. SIGNATURE J. T. Hoff, M.D.		22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 12/17/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-20-1962		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			23d. LOCATION (City, town, or county) (State) St. Louis, Missouri								
24. FUNERAL DIRECTOR Stock Mortuaries, 2117 E. Grand				ADDRESS		25. DATE RECD. BY LOCAL REG. DEC 19 1962		26. REGISTRAR'S SIGNATURE Paul Smith, M.D.							

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59
1
2 **2109**
3
4 **0**
5 **1**
6
7 **0**
8 **2**
9
10
11
12 **75-0**
13

75

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH

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 Paul A. Wachtel

Licensed Embalmer No. 4797

P. O. Address Shreveport

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.