

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-022206

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5191** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH a. COUNTY		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) St. Louis		Length of stay in lb 6 Days	c. CITY OR TOWN Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 108 Glen Garry Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First GEORGE Middle SCHUMACHER Last			4. DATE OF DEATH Month May Day 11 Year 1963		
5. SEX Male	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 2/8/04	9. AGE (last birthday) 59	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) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Steel	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME George Schumacher		13b. MOTHER'S MAIDEN NAME Gertrude Schroer		14. NAME OF HUSBAND OR WIFE Bernice Hoelter Schumacher	
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 Geraldine Braun, 108 Glen Garry (37)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **Bilateral lobar pneumonia,**
Left upper, right upper,
DUE TO (b) **Fracture of the 4th lumbar vertebra of severe degree**
DUE TO (c)

CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) When auto driven by deceased hit pole
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20c. TIME OF INJURY
Hour **4:07** a.m. **5/5/63** Month, Day, Year

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.) Street	20f. CITY, TOWN, OR LOCATION St. Louis, Missouri	COUNTY St. Louis	STATE Missouri
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21. I attended the deceased from **400A** to _____ and last saw him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title)	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 5-14-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/15/63	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR BUCHHOLZ MORTUARY, INC. 5967 W. Florissant	25. DATE RECD. BY LOCAL REG. MAY 14 1963	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DATE AMENDED
6/24/63

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
Fracture of 4th lumbar vertebra of severe degree
80a-20f. Accident - auto hit pole - street, St. Louis, Mo.
BY AFFIDAVIT OF 4:07 a.m. 5/5/63 not while working

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

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 Ralph E. Lunders

Licensed Embalmer No. 4275

P. O. Address Al. Louis 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.