

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026363

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6430** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

VS 300
Rev. 4/59

1

2 *2089*

3

4 *1*

5 *1*

6

7 *0*

8 *1*

9

10

11

12 *75-0*

13

75

USE BLACK INK OR TYPEWRITER RIBBON

R. IDZON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

FILED JUN 28 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO.		a. STATE Mo.	b. COUNTY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 1519 Grape	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last FANNIE SCHROEDER			4. DATE OF DEATH Month Day Year 6 17 1963.			
5. SEX Female	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 1/30/1890	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (City and state or country) Montauk, Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME John Kell		13b. MOTHER'S MAIDEN NAME Sarah Mooney		14. NAME OF HUSBAND OR WIFE John 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 Beatrice Kipp 1519 Grape	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *M. ventral artery thrombosis*

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____

DUE TO (c) *570.2*

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal condition given in PART I (a):
Coronary Artery Sclerotic Disease

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"/>	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.	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 **5, 24, 63.** to **6, 17, 63.** and last saw her alive on **6, 17, 63.**
Death occurred at **4:10 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Thomas J. Kell MD</i>	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED (State) 6, 17, 63.
--	--	---

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/19/63	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
---	-----------------------------	---	---

24. FUNERAL DIRECTOR <i>Allen Kell</i>	ADDRESS 7267 Natural Bridge	25. DATE RECD. BY LOCAL REG. JUN 19 1963	26. REGISTRAR'S SIGNATURE <i>Loed Smith, M.D.</i>
---	---------------------------------------	--	--

