

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026766

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1921 STATE FILE NUMBER

FILED JUL 1 1963

1. PLACE OF DEATH a. COUNTY <u>St Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fenton</u> Length of stay in lb <u>4 mos.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fieser Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u> c. CITY OR TOWN <u>Fenton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Rt 1 Box 572</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
---	--	--	--

3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle Last <u>Schoener</u>			4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1963</u>		
--	--	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1, 1878</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
----------------------	-------------------------------	--	--------------------------------------	----------------------------------	---------------------------	------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	-----------------------------------	--	--

13a. FATHER'S NAME <u>August Potthast</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</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.	17. INFORMANT Address <u>Edna Latham Rt1 Box572 Fenton Mo.</u>
---	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO (b) <u>C.V.A.</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>30 hrs</u>
---	--	--

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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
---	--	---	--	--

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 3/29/63 to date and last saw her alive on 6/13/63
 Death occurred at 51st St on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Frank Huck M.D.</u>	22b. ADDRESS <u>Fenton, Mo</u>	22c. DATE SIGNED <u>6/14/63</u>
---	--------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/17/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Paul Churchyard</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis County Mo.</u>
---	--------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>John L Ziegenhein & Sons 7027 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>6-14-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Mumfry M.D.</u>
---	---	--

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

1 4000

2 4000

3

4 1

5 3

6

7 0

8 2

9 331X

10

11

12 86-0

13

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 Donald Berry

Licensed Embalmer No. 9853

P. O. Address St 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.