

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034078

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8716**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS</b>		c. CITY OR TOWN <b>ST LOUIS</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST ANTHONYS</b>		d. STREET ADDRESS (If outside, give location) <b>4101 DEWEY</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN J SCHMITZ</b>		4. DATE OF DEATH Month Day Year <b>AUG 27 1963</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 20 1909-53</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MEAT CUTTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Mo</b>
12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>		13a. FATHER'S NAME <b>CHARLES SCHMITZ</b>	
13b. MOTHER'S MAIDEN NAME <b>MARY TILLMAN</b>		14. NAME OF HUSBAND OR WIFE <b>MILDRED SCHMITZ</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of entry) <b>YES</b>		17. INFORMANT Address <b>188 RAY PAWLOSKI 724 N 18th</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction with</b> DUE TO (b) <b>Ventricular tachycardia</b> DUE TO (c) <b>arterio-sclerotic heart disease with myocardial ischemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 mos</b>
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. <b>4200</b> <input type="checkbox"/> Yes <input 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 <b>May 10 - 1963</b> to <b>August 27 - 63</b> last saw him alive on <b>Aug. 27 - 1963</b> Death occurred at <b>9:30 p</b> m on the date stated above, and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Deceased or title) <b>George A. O'Sullivan, M.D.</b>		22b. ADDRESS <b>7629 Ivory Ave</b>	
22c. DATE SIGNED <b>8-28-63</b>		23. NAME OF CEMETERY OR CREMATORY <b>NATIONAL</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>Aug 30, 1963</b>	
23c. LOCATION (City, town, or county) (State) <b>ST LOUIS Co. Mo</b>		24. GENERAL DIRECTOR ADDRESS <b>Thomas Kutas 2906 Travis</b>	
25. DATE RECD. BY LOCAL REG. <b>8-29-1963</b>		26. REGISTRAR'S SIGNATURE <b>Road Smith, M.D.</b>	

VS 300 Rev. 4/59

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DATE AMENDED 9-12-63

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF Widowed

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Funeral Director

SHOULD READ Married

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 *Cooley Thompson*

Licensed Embalmer No. 486

P. O. Address St. Louis 19, 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.

*Mr. O' Sullivan*  
*7629 January*  
*CE 2 12422 1-3 Med.*