

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-034083**  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8224**

**FILED AUG 22 1963**

**DO NOT WRITE ON THIS STUB**

AMENDED

VS 300  
Rev. 4/59

1  
2 *2019*  
3  
4 *1*  
5 *2*  
6  
7 *0*  
8 *2*  
9  
10  
11  
12 *86-0*  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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 <b>St. Louis, Mo.</b>		a. STATE <b>Mo.</b> b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Little Flower Conv. Home</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3695 Dover Pl.</b>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Emma M. Schoy</b>			4. DATE OF DEATH Month Day Year <b>Aug. 10, 1963</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE (last birthday) <b>86</b>
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Matthias Kossenjans</b>		13b. MOTHER'S MAIDEN NAME <b>Julia Spissinger</b>	14. NAME OF HUSBAND OR WIFE <b>John Schoy</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>[redacted]</b>	
17. INFORMANT <b>Mrs. Emily Schneider</b>		Address <b>3695 Dover Pl.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>331X</b>			
DUE TO (c)			
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 <b>1950</b> to <b>8-10-63</b> and last saw her him alive on <b>8-7-63</b> Death occurred at <b>2 p.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>E. H. Smith M.D.</b>		22b. ADDRESS <b>3654 S Grand</b>	
22c. DATE SIGNED <b>8-12-63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>8-13-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Southern Funeral Home 6322 S. Grand, St. Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 13 1963</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith. M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

Schroy

Mr. Nestor + Murchison  
To 3 Grand + Annie Boger  
3654. Grand

no 4-5567

**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 James C. Hill

Licensed Embalmer No. 4347

P. O. Address 6302 De Grand

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.