

FILED MAR 8 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 7032  
00305

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6574		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY OR TOWN <u>Rural, Normandy, Mo.</u>		c. LENGTH OF STAY (In this place) <u>7 months</u>		c. CITY OR TOWN <u>Rural Normandy township</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>None 7449 Merrillac Drive</u>				d. STREET ADDRESS (If rural, give location) <u>7449 Merrillac Drive</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fred</u>		b. (Middle) <u>William</u>		c. (Last) <u>Schuttenberg</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 5 1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>		8. DATE OF BIRTH <u>Mar. 16-1862</u>	
9. AGE (In years last birthday) <u>86</u>		10. UNDER 1 YEAR Months _____ Days _____		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work including most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Karl Schuttenberg</u>			13b. MOTHER'S MAIDEN NAME <u>Maria Charlotte Beineck</u>			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE, NAME AND ADDRESS <u>Mrs. Wm. Skroska, 7449 Merrillac Drive, Normandy, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio Sclerotic Heart Disease</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>93d</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>12/27, 1948</u> , to <u>2/5, 1949</u> , that I last saw the deceased alive on <u>2/5, 1949</u> , and that death occurred at <u>10:40 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>John P. Ferrara MD</u>				23b. ADDRESS <u>7307 Natural Bridge</u>		23c. DATE SIGNED <u>2/7/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 8-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. John, Bellefontaine</u>		24d. LOCATION (City, town, or county) (State) <u>Bellefontaine Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2/8/49</u>		REGISTRAR'S SIGNATURE <u>Shirley L. Young MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Schrader Funeral Home, Ballwin Mo.</u>			

(Licensed Embalmers' Certificate on Reverse Side)

No. 300

10.48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.

Signed \_\_\_\_\_

*Hea Schrader*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *3066*

P. O. Address *Bellevue, 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 this body is not embalmed, fact should be so stated above.