

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10608
State File No. 2107
Registrar's No.

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 2155a Russell Boulevard			
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital				d. STREET ADDRESS (If rural, give location) 2155a Russell Boulevard					
3. NAME OF DECEASED (Type or Print) a. (First) MINNIE			b. (Middle) _____		c. (Last) SCHETTLE		4. DATE OF DEATH (Month) (Day) (Year) March 3, 1949		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH March 26-1889		9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) St. Charles, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.		
13a. FATHER'S NAME Fritz Borchardt			13b. MOTHER'S MAIDEN NAME Minnie (Unknown)			14. NAME OF HUSBAND OR WIFE Leo L. Schettle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Leo L. Schettle ADDRESS A 2155a Russell Bl.					
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) Brain Tumor - 10				INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) None 56					
				DUE TO (c) 237X					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				Hypertension - Optic Atrophy				5-10 yrs	
19a. DATE OF OPERATION 2/25/49		19b. MAJOR FINDINGS OF OPERATION Acoustic Neuroma (8th Nerve Tumor)						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____		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 2/11 , 1949, to 3/3 , 1949, that I last saw the deceased alive on 3/3 , 1949, and that death occurred at 8:15 P.M. from the causes and on the date stated above.									
23a. SIGNATURE Edmund A. Smolik M.D. (Degree or title)				23b. ADDRESS Beaumont Mrs Bldg			23c. DATE SIGNED 3/4/49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 7-1949		24c. NAME OF CEMETERY OR CREMATORY New St. Marcus		24d. LOCATION (City, town, or county) St. Louis, Mo. (State) _____			
DATE REC'D BY LOCAL REG. MAR 7 1949		REGISTRAR'S SIGNATURE J. B. Rasater			25. FUNERAL DIRECTOR'S SIGNATURE Mayall Wood ADDRESS 1926 Allen Ave.				

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

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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.....

Me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Benj. C. Duncan

Licensed Embalmer No. 2272

P. O. Address 1926 Allen Avenue

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.