

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **21634**  
**5266**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** 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 <b>Missouri</b> b. COUNTY <b>Madison</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>City Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>27</b> <b>2823 S. 13th St.</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Antonette</b> b. (Middle) c. (Last) <b>Schmidt</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>6 15 1949</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March 31, 1885</b>
9. AGE (In years last birthday) <b>64</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Germany</b>
12. CITIZEN OF WHAT COUNTRY? <b>4</b>		13. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>Ernst Mussback</b>		13b. MOTHER'S MAIDEN NAME <b>Ida Blauwtz</b>	
14. NAME OF HUSBAND OR WIFE <b>John Schmidt</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <b>John Schmidt</b>	
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.		19. ADDRESS <b>2823 S. 13th St.</b>	
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) _____  ANTECEDENT CAUSES <b>Due to (b) Cerebral Apoplexy</b> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21b. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>830</b>	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR? <b>334X</b>		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>6:10 P.</b> m., from the causes and on the date stated above.	
23. SIGNATURE (Degree or title) <b>Patrick E. Taylor Cor. B</b>		23b. ADDRESS <b>1300 Clark</b>	
23c. DATE SIGNED <b>6-16-49</b>		24. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
24a. DATE <b>6-18-1949</b>		24b. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus</b>	
24c. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		24d. DATE REC'D BY LOCAL REG. <b>JUN 17 1949</b>	
24e. REGISTRAR'S SIGNATURE <b>J. B. Lasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Weick Bro. Und. Co.</b>	
24f. ADDRESS <b>2201 S. Grand</b>		25. ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

*James R. Allen*

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

Licensed Embalmer No. 4527

P. O. Address 2201 S Grand

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.