

FILED JUN 15 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **18628**
Registrar's No. **4864**

BIRTH NO. 21428-50		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 4864			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY ST. LOUIS					
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 2 Days		c. CITY (If outside corporate limits, write RURAL and give township) Bethesda Grover Mo		d. STREET ADDRESS (If rural, give location) Tandy Lane 9750			
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital									
3. NAME OF DECEASED (Type or Print) a. (First) Baby Infant b. (Middle) Schueler c. (Last) Schueler				4. DATE OF DEATH (Month) (Day) (Year) 5-29-1950					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child		8. DATE OF BIRTH 5-27-1950			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME William Schueler			13b. MOTHER'S MAIDEN NAME Marcella Partner		14. NAME OF HUSBAND OR WIFE None				
15. WILLIAM 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 ADDRESS W. Schueler Ballwin Mo					
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) Renovascular Respiratory failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. menstruity DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 2738-					
22. I hereby certify that I attended the deceased from 5/27 , 19 50 to 5/29 , 19 50 , that I last saw the deceased alive on 5/29 , 19 50 and that death occurred at 3 p. m. , from the causes and on the date stated above.									
23a. SIGNATURE Marianne Kuttner MD				23b. ADDRESS 634 North Grand		23c. DATE SIGNED 5/31/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-30-50		24c. NAME OF CEMETERY OR CREMATORY Suburban		24d. LOCATION (City, town, or county) (State) Mo			
DATE RECD BY LOCAL REG JUN 2 1950		REGISTRAR'S SIGNATURE J. B. Parater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Schraden Funeral Home Ballwin Mo					

(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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed Wm M Digmore

Licensed Embalmer No. 4243

P. O. Address St Louis 10

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.