

FILED AUG 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Hulbert

29061

State File No.

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **1937**

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) Pine Lawn		c. LENGTH OF STAY (in this place) _____	
c. CITY (If outside corporate limits, write RURAL and give township) Belleville		8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION Shamrock Nursing Home		d. STREET ADDRESS (If rural, give location) Unknown	
3. NAME OF DECEASED (Type or Print) a. (First) Bessie		b. (Middle) Schott	
c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) 8 10 50	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH SEPT 20 - 1876
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Belleville, Ill		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Edward Schott		13b. MOTHER'S MAIDEN NAME Christian Rindner	
14. NAME OF HUSBAND OR WIFE Edward Schott		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unk	
16. SOCIAL SECURITY NO. unk		17. INFORMANT'S SIGNATURE OR NAME Pete Haedner ADDRESS Belleville	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Atherosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. HOW DID INJURY OCCUR _____	
22. I hereby certify that I attended the deceased from June 1950 , to date , 19 50 , that I last saw the deceased alive on Aug 20 , 19 50 , and that death occurred at 7 P.M. , from the causes and on the date stated above.		23a. SIGNATURE Beard Hulbert (Degree or title) _____	
23b. ADDRESS Beaumont Bldg		23c. DATE SIGNED Aug 11/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removed		24b. DATE 5/8/50	
24c. NAME OF CEMETERY OR CREMATORY Belleville		24d. LOCATION (City, town, or county) Belleville Ill	
DATE REC'D BY LOCAL HEALTH DEPT. AUG 12 1950		REGISTRAR'S SIGNATURE Hulbert L. Klouke, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.		ADDRESS 4104 Manchester Ave. St. Louis 10, Mo.	

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.

Student
Student Embalmer

Signed

J. Allen Davis
Licensed Embalmer No. 4053

P. O. Address M. J. ...

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.