.S. No. 300
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JAN 26 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3293

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0467

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3518 S. Jefferson

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis 2247
d. STREET ADDRESS (If rural, give location) 3518 S. Jefferson Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Marie
b. (Middle) Margaret
c. (Last) Schott

4. DATE OF DEATH (Month) (Day) (Year) Jan. 15, 1952

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Apr. 25, 1864
9. AGE (In years last birthday) 87 | If under 1 year: Months | Days | If under 24 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) Germany 4
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Gerhart Meier
13b. MOTHER'S MAIDEN NAME Flaxchscopt
14. NAME OF HUSBAND OR WIFE Fred Schott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. No
17. INFORMANT'S SIGNATURE OR NAME Sophie Seyferth **ADDRESS** 3518 S. Jefferson

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 12 yrs
DUE TO (c)

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 ☐ NO ☑

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4521

22. *I hereby certify that I attended the deceased from* Jan. 2nd, 1952 *to* Jan 15, 1951, *that I last saw the deceased alive on* Jan 13, 1952 *and that death occurred at* 1:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE William Baron (Degree or title) M.D.
23b. ADDRESS 3601 A S Jefferson
23c. DATE SIGNED Jan. 15-52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Jan. 17, 1952
24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cem.
24d. LOCATION (City, town, or county) (State) St. Louis, County

DATE REC'D BY LOCAL REG. JAN 16 1952
REGISTRAR'S SIGNATURE Earl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE W. T. Bros. **ADDRESS** 2929 S. Jefferson Ave.

(Licensed Embalmer's Statement on Reverse Side)

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 D. M. Davis

Signed.....
Student Embalmer

Licensed Embalmer No. 374

P. O. Address 2929 Jefferson av

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.