

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18507**
Registrar's No. **4719**

FILED JUN 6 1952

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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 2249	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3543 Pennsylvania		d. STREET ADDRESS (If rural, give location) 24 3543 Pennsylvania			
3. NAME OF DECEASED (Type or Print) Catherine		a. (First)	b. (Middle)	c. (Last) Schmit	4. DATE OF DEATH (Month) (Day) (Year) 5/20/52
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Aug. 30, 1859	9. AGE (In years last birthday) 92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Luxenberg, Germany	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE ---		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT'S SIGNATURE OR NAME Frank Schmit		ADDRESS --3701 Keokuk St.			
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) Chronic Myocarditis			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) / DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile dementia			3 mos.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			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? 4222	
22. I hereby certify that I attended the deceased from 6-21-51 , to 5-20-52 , that I last saw the deceased alive on 5-20-52 , and that death occurred at 6:05 a.m. , from the causes and on the date stated above.					
23a. SIGNATURE M.W. Hansloser M.D.		(Degree or title)		23b. ADDRESS 136 74 Arsenal St	
23c. DATE SIGNED 5-21-52		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5/23/52	
24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri			
DATE REC'D BY LOCAL REG. MAY 22 1952		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Kelderle	
		ADDRESS 3634 Gravois			

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

Robert Wheeler

Licensed Embalmer No. 2028

P. O. Address St Louis Mo

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.