

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

State File No. 22614

5154

FILED JUN 27 1952

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

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 2069

d. FULL NAME OF HOSPITAL OR INSTITUTION DEACONESS HOSP d. STREET ADDRESS (If rural, give location) 4940 HIGHLAND AVE

3. NAME OF DECEASED a. (First) LOUIS b. (Middle) SCHROEDER c. (Last) _____ 4. DATE OF DEATH (Month) (Day) (Year) 6-3-52

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 8. DATE OF BIRTH about 1879 9. AGE (In years last birthday) 73 10. UNDER 1 YEAR Months _____ 11. UNDER 1 YEAR Days _____ 12. UNDER 1 YEAR Hours _____ 13. UNDER 1 YEAR Min. _____

10a. USUAL OCCUPATION (Give kind of work and during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Haged Wheel Co 11. BIRTHPLACE (State or foreign country) Tell City, Indiana 12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME Not Known 13b. MOTHER'S MAIDEN NAME Not Known 14. NAME OF HUSBAND OR WIFE Katherine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert Schuster Gatesworth, Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HEPATIC COMA
INTERVAL BETWEEN ONSET AND DEATH 4 DAY
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CIRRHOSIS OF THE LIVER UNKNOWN.
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 (Month) (Day) (Year) (Hour) OF INJURY _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 5810

22. I hereby certify that I attended the deceased from 5-27, 1952, to 6-3, 1952, that I last saw the deceased alive on 6-3, 1952, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE Robert E. Koel (Degree or title) M.D. 23b. ADDRESS 35 N. CENTRAL PLATON Mo 23c. DATE SIGNED 6/5/52

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 6/6/52 24c. NAME OF CEMETERY OR CREMATORY New St. Marcus St. Louis Co Mo 24d. LOCATION (City, town, or county) (State) _____

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUN 5 1952 _____ 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. Krowl & Co 2707 N. Grand

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No history of alcoholism

DEC 5 1953

MAR 25 1953

MAR 23 1954

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 *Irona Williamson*

Signed.....
Student Embalmer

Licensed Embalmer No. 2565

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.