

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3731

FILED JAN 28 1953

State File No. _____

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 0551

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, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		d. STREET ADDRESS (If rural, give location) 16 3339 LOUISIANA⁰	
3. NAME OF DECEASED (Type or Print), JOSEPH		a. (First) JOSEPH	b. (Middle) SCHNELL
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) JANUARY 17, 1953	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH NOV. 13 1862
9. AGE (In years) 90		10. MONTHS 4	11. DAYS 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and State or Foreign Country) AUSTRIA 4
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME JOSEPH SCHNELL	
13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE JOHANNA SCHNELL (DECD)	
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. NONE	
17. INFORMANT'S SIGNATURE OR NAME JOSEPH E. SCHNELL		ADDRESS 3339 LOUISIANA	
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) Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbidity 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.		Trigeminal Herpes Zoster	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input 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? 331X		22. I hereby certify that I attended the deceased from 1-12-53 , 19____, to 1-17-53 , 19____, that I last saw the deceased alive on 1-17-53 , 19____, and that death occurred at 1:30A m., from the causes and on the date stated above.	
23a. SIGNATURE Edward P. Flynn M.D. (Degree or title)		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 1-17-53		24a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	
24b. DATE JAN 19 1953		24c. NAME OF CEMETERY OR CREMATORY VALHALLA CREMATORY	
24d. LOCATION (City, town, or county) (State) ST. LOUIS MO		25. FUNERAL DIRECTOR'S SIGNATURE W. Thomas Kutz ADDRESS 2906 Travis	
DATE REC'D BY LOCAL REG. JAN 19 1953		REGISTRAR'S SIGNATURE Carl Smith	

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 *Homer C. Hill*

Licensed Embalmer No. *4347*

P. O. Address *2506 Francis*

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.