FILED JUL 2 - 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23144

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5994

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Park Lane Hospital
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)

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
d. STREET ADDRESS (If rural, give location): 24 1956 Cherokee St 2271 D

3. NAME OF DECEASED (Type or Print)
a. (First): Maude
b. (Middle): O.
c. (Last): Schmitt

4. DATE OF DEATH (Month) (Day) (Year): 6-16-1953

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 4-13-1880
9. AGE (In years last birthday): 73 — 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): At Home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Marion Quick
13b. MOTHER'S MAIDEN NAME: Maud Martin
14. NAME OF HUSBAND OR WIFE

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.: None
17. INFORMANT'S SIGNATURE OR NAME: Gertrude Schmitt — ADDRESS: 1956 Cherokee St

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute dilatation of heart. — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Myocarditis.

DUE TO (c) Hypertension.

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: No surgery.
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? 443X

22. *I hereby certify that I attended the deceased from* Feb. 26, *1953, to* June 14, *1953, that I last saw the deceased alive on* June 14, *1953, and that death occurred at* 6:55 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.
23b. ADDRESS: 4930 Lindell Blvd. St. Louis 8, Missouri
23c. DATE SIGNED: 6-15-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 6-17-1953
24c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park
24d. LOCATION (City, town, or county) (State): 10160 Gravois Road Affton Mo

DATE REC'D BY LOCAL REG.: JUN 16 1953
REGISTRAR'S SIGNATURE: J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ziegenheim Bros 6409 Gravois Ave

(Licensed Embalmer's Statement on Reverse Side)

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 .....

working under my personal supervision.

Student Embalmer No. .....

Signed Van M. Szymon

Signed .....
Student Embalmer

Licensed Embalmer No. 4343

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.