

FILED OCT 1 - 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **33993**BIRTH NO. **66194**REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**Registrar's No. **8071**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City 4356		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			d. STREET ADDRESS (If rural, give location) 7257a Balson Ave.		
3. NAME OF DECEASED (Type or Print)		a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
		Steven	Courtney	Schaus	Aug. 18, 1953
5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
M.	W.	S.		Aug. 13, 1953	0 0 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Harold Schaus		13b. MOTHER'S MAIDEN NAME Marillyn Courtney		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. non		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Harold Schaus, 7257a Balson Ave.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION		
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory Failure			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) Prematurity					
DUE TO (c) Partial Separation of Placenta					
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 <input checked="" 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)	
				7615	
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?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ p. m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Frank D. Robertson, M.D.			23b. ADDRESS 634 No. Grand Ave.		23c. DATE SIGNED 8-19-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 19, 1953	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. AUG 19 1953		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		FUNERAL DIRECTOR'S SIGNATURE ADDRESS Donnelly, 3840 Lindell Blvd	

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 *J. Willis Williamson*

Licensed Embalmer No. 3565

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.