

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **14058**
3852

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| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | 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, MISSOURI | | c. LENGTH OF STAY (In this place) _____ | | c. CITY OR TOWN ST. LOUIS | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL | | | | e. STREET ADDRESS (If rural, give location) 24 3548⁹ NEBRASKA 2249 | | | | | |
| 3. NAME OF DECEASED (Type or Print) ELEANOR | | a. (First) | | b. (Middle) | | c. (Last) SCHINDLER | | 4. DATE OF DEATH (Month) (Day) (Year) APRIL 26, 1954 | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED | | 8. DATE OF BIRTH AUG. 14, 1892 | | 9. AGE (In years last birthday) 61 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 (City and State or Foreign Country) MISSOURI | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME JOHN REARDON | | | 13b. MOTHER'S MAIDEN NAME ELIZABETH IMMER | | | 14. NAME OF HUSBAND OR WIFE ALOIS SCHINDLER | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____ | | | 16. SOCIAL SECURITY NO. _____ | | | 17. INFORMANT'S SIGNATURE OR NAME LORETTA BRINKER ADDRESS 2844⁹ NEMP | | | |
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Status asthmaticus ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic bronchitis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Depressive reaction | | | | | | INTERVAL BETWEEN ONSET AND DEATH 9 hours 5 months | |
| 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) 502.1 | | | | | |
| 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 3-18-54 , 19____, to 4-26-54 , 19____, that I last saw the deceased alive on 4-26-54 , 19____, and that death occurred at 6:25P m., from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) Robert F. Owen, M.D. | | | | 23b. ADDRESS 1515 Lafayette Avenue | | 23c. DATE SIGNED 4-27-54 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24b. DATE 4-29-54 | | 24c. NAME OF CEMETERY OR CREMATORY S.S. PETER & PAUL CEM | | 24d. LOCATION (City, town, or county) (State) ST. LOUIS MO | | | |
| DATE REC'D BY LOCAL REG. APR 28 1954 | | REGISTRAR'S SIGNATURE J. Carl Smith | | | FEDERAL DIRECTOR'S SIGNATURE ADDRESS Thomas G. Jettis 2906 Lincoln | | | | |

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.....
Signature of Student Embalmer

Signed *Samuel C. Hill*.....
Student Embalmer No.....

Licensed Embalmer No. *434*.....

P. O. Address *2906*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.