

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38834  
State File No. 10494  
Registrar's No.

BIRTH NO. 83263-55 REG. DIST. NO. 318 PRIMARY-REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY OR TOWN <u>St. Louis</u>	c. LENGTH OF STAY (in this place) <u>12 days</u>	c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Anthony's</u>		e. STREET ADDRESS (If rural, give location) <u>17 4047 Shenandoah</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Debra</u> b. (Middle) <u>Schmidt</u> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>11/29/55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>Nov. 17 1955</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>12</u>	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>self</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>Frank Schmidt</u>	13b. MOTHER'S MAIDEN NAME <u>Virginia Arnold</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. V. Schmidt</u>	ADDRESS <u>4047 Shenandoah</u>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congenital malformation of esophagus</u>		<u>10 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>TRACHEO-ESOPHAGEAL FISTULA</u>		<u>10 days</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>ATELECTASIS (lung)</u>		<u>10 days</u>	

19a. DATE OF OPERATION <u>11/19/55</u>	19b. MAJOR FINDINGS OF OPERATION <u>TRACHEO-ESOPHAGEAL FISTULA</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>756.2</u>	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?	

22. I hereby certify that I attended the deceased from 11/17, 1955, to 11/30, 1955, that I last saw the deceased alive on 11/29, 1955, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert P. Smith M.D.</u> (Degree or title)	23b. ADDRESS <u>5203 Cluffe IV</u>	23c. DATE SIGNED <u>11/30/55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>12/1/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mayfield</u>
24d. LOCATION (City, town, or county) (State) <u>Carlinville, Illinois</u>		

DATE REC'D BY LOCAL REG. <u>NOV 30 1955</u>	REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>	FUNERAL DIRECTOR'S SIGNATURE <u>A. Howard</u>	ADDRESS <u>1619 So. Grand</u>
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mjb (Licensed Embalmer's Statement on Reverse Side)

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

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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 *J. W. Bentley*.....

Licensed Embalmer No. *375*.....

P. O. Address *St. Paul*.....

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.

*my*