

7189

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED FEB 17 1956

Registrar's No. **1166**BIRTH NO. \_\_\_\_\_ 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 <b>Mo.</b> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Louis</b>		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 <b>St. Anthony Hospital</b>			e. STREET ADDRESS (If rural, give location) <b>14 6371a Sutherland Ave.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>OTTO</b>		b. (Middle) <b>K.</b>	c. (Last) <b>SCHUBERT</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 1 1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 7, 1910</b>	9. AGE (In years last birthday) <b>45</b>	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) <b>Catering Manager-Old Warson Club</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Otto Schubert</b>		13b. MOTHER'S MAIDEN NAME <b>Rosa Koch</b>		14. NAME OF HUSBAND OR WIFE <b>Hildegard Schubert</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War 2</b>		16. SOCIAL SECURITY NO. <b>494-10-0409</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Hildegard Schubert 6371a Sutherland</b>		
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, asthma, etc. It means the disease, injury, or complication which caused death.		<p align="center"><b>MEDICAL CERTIFICATION</b></p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hepatic Coma</b> ANTECEDENT CAUSES <b>Acute cholangitic hepatitis</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>585x</b>			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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 <b>26 Jan 1956</b> , to <b>1 Feb. 1956</b> that I last saw the deceased alive on <b>31 Jan 1956</b> and that death occurred at <b>12:30<sup>A</sup></b> m., from the causes and on the date stated above.					
23a. SIGNATURE <b>C. W. Hoffmann</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>16 Hampton Village Plaza</b>		23c. DATE SIGNED <b>2/3/56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Feb. 3, 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>		
DATE REC'D BY LOCAL REG. <b>FEB 3 1956</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Kriegshauser 4228 S. Kingshighway Bl.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

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No. 300

10.48

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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 *Richard W. Storran*.....

Licensed Embalmer No. *400*.....

P. O. Address.....

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.