

FILED APR 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **14840****318**PRIMARY REG. DIST. NO. **1003**Registrar's No. **3463**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3463	
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		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 Deaconess Hospital				STREET ADDRESS (If rural, give location) 5416 Queens Ave. 20740			
3. NAME OF DECEASED (Type or Print)		a. (First) Jacob		b. (Middle) William		c. (Last) Schiele	
4. DATE OF DEATH		a. (Month) April		b. (Day) 6,		c. (Year) 1956	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 27, 1872	
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 1 YEAR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agency		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (City and State or Foreign Country) St. Jacobs, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Jacob Schiele		13b. MOTHER'S MAIDEN NAME Sylvia Winterroth		14. NAME OF HUSBAND OR WIFE Clara Schiele			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clara Schiele, 5416 Queens 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC INSUFFICIENCY ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ADENOCARCINOMA OF PROSTATE. 177X				INTERVAL BETWEEN ONSET AND DEATH 1 WK. 1-2 MO'S.	
19a. DATE OF OPERATION 3.14.56		19b. MAJOR FINDINGS OF OPERATION ADENOCARCINOMA OF PROSTATE. #20.0				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.) _____		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 March 7, 1956 to Apr. 6, 1956 , that I last saw the deceased alive on Apr. 5, 1956 , and that death occurred at 4:00A.M. , from the causes and on the date stated above.							
23a. SIGNATURE Robert E. Koch		(Degree or title) M.D.		23b. ADDRESS 35 N. Central, Clayton, Mo.		23c. DATE SIGNED 4-6-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4/9/56		24c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri	
DATE REC'D BY LOCAL REG. APR 6 1956		REGISTRAR'S SIGNATURE J. Carl Smith, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PROVOST UND. CO., 3710 No. Grand Bl.			

(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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *William Branson*

Licensed Embalmer No. *476*

P. O. Address *St. Louis,*

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.