

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15261

STATE FILE NUMBER

FILED APR 29 1957

318

Registration District No.

Primary Registration District No. 1003

Registrar's No. 2666

Health, & Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Maplewood 3 HOOF		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital			Length of stay in 1b		d. STREET (If outside, give location) ADDRESS 7117 Kensington
3. NAME OF DECEASED (Type or print) First MIDDLE Last LESTER CHARLES SCHULZ JR.			4. DATE OF DEATH Month Day Year Mar. 16 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep. 10, 1956	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months Days Hours Min. 6 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lester Charles Schulz Sr.			14. MOTHER'S MAIDEN NAME Ann Gaffney		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Lester C. Schulz Sr. 7117 Kensington		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Virus Gastroenteritis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>571.0</u>					INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>4 days</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>3-12-57</u> to <u>3-16-57</u> and last saw her/him alive on <u>3-16-57</u> . Death occurred at <u>5:45 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Eugene H. Godele M.D.</u> (Degree or title)			22b. ADDRESS <u>+971 Chippenwa St.</u>		22c. DATE SIGNED <u>3-18-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE <u>Mar. 19, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
24. FUNERAL DIRECTOR <u>Kriegshauser</u>		ADDRESS <u>4228 S. Kingshighway</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 18 '57</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith mo</u> <u>mgc</u>

(Licensed Embalmer's Statement on Reverse Side)

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 *John A. [Signature]* .....

Licensed Embalmer No. 453 .....

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.