

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 31 1957

State File No. **19270**
4764

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY St. Louis,		2. USUAL RESIDENCE (Where deceased lived. If institution: ranklesse' before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		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 4205 Peck Av.		e. STREET ADDRESS (If rural, give location) 4205 Peck Av.	

3. NAME OF DECEASED (Type or Print) Edith Helen Schroeder			4. DATE OF DEATH (Month) (Day) (Year) 5/19/57		
a. (First)	b. (Middle)	c. (Last)			

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 3/1/83	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mts. _____
----------------------	-------------------------------	---	--------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At. Home	11. BIRTHPLACE (City and State or Foreign Country) Bonne Terre, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
---	--	---	---	--	---

13a. FATHER'S NAME Ben Cummings		13b. MOTHER'S MAIDEN NAME Ida Compton		14. NAME OF HUSBAND OR WIFE Charles A. Schroeder	
--	--	--	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 408-36-8756	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Audrey A. Parker 4205 Peck Av.			
--	--	---	--	--	--

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, assthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cs of Brawl. E ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) P.O. subarachnoid extension DUE TO (c) + massive hemorrhage II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH May 1956.
--	--	--	--	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 153+		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
------------------------	--	--	--

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 **April 1957** to **May 19, 1957**, that I last saw the deceased alive on **19**, 19**57**, and that death occurred at **4:30 PM** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. J. J. Keenan M.D.	23b. ADDRESS 3504 N. 11th St	23c. DATE SIGNED 5-20-57
---	-------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5/22/57	24c. NAME OF CEMETERY OR CREMATORY Jaural Hill Garden	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
--	--------------------------	--	---	--

DATE REC'D BY LOCAL REG. MAY 21 57	REGISTRAR'S SIGNATURE Carol Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bull Campbell Mort. 5165 Delmar Bl.		
---	---	---	--	--

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.....
John J. Haines

Licensed Embalmer No. *4168*
P. O. Address: *St. Louis, Mo.*

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.