FILED FEB 14 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH 12768-58

3567

Registration District No. 318 Primary Registration District No. 1003 STATE FILE NUMBER 1356 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Evangelical Deaconess Hospital — Length of stay in Hospital 6hrs 21min

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 5317 Devonshire — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Steven Middle Michael Last Schroeder
4. DATE OF DEATH: Month 1 Day 23 Year 1958
5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-23-1958
9. AGE (In years last birthday) — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours 6, Min. 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert Edward Schroeder
14. MOTHER'S MAIDEN NAME: Shirley Mae Ritter.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Shirley M. Schroeder — Address 5317 Devonshire St. Louis 9, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis, Pulmonary, Bilat
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Prematurity
DUE TO (c) 762.5
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1-23-58, to 1-23-58 and last saw ~~him~~ him alive on 1-23-58.
Death occurred at 6:53 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Jerry Fall MD (Degree or title)
22b. ADDRESS 35 N. Central Ave
22c. DATE SIGNED 2-4-1958

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2-28-58
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board
23d. LOCATION (City, town, or county) St. Louis, Mo. (State)

24. FUNERAL DIRECTOR Rowland Akers ADDRESS 4104 Manchester
25. DATE RECD. BY LOCAL REG. FEB 5 58
26. REGISTRAR'S SIGNATURE J. Earl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.