. Health,
& Welfare
. Public
h Service

S. 300
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-027427
STATE FILE NUMBER

FILED JUL 18 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6806

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: 01 2314 S. 10th — Length of stay in 1b: 2
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY: 1
c. CITY OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2390 2314 S. 10th — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First LYDIA Middle Last SCHOMAKER
4. DATE OF DEATH: Month JULY Day 6 Year 1958
5. SEX: Female
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: SEPT 1 1878
9. AGE (In years last birthday): 79 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): TENNESSEE
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME: ARTHUR SCHOMAKER
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND ~~OR WIFE~~: HENRY SCHOMAKER (DEC'D)
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: ARTHUR SCHOMAKER — Address: 1444 BALI COURT

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio sclerotic Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arterio Sclerosis
DUE TO (c): 420.0
INTERVAL BETWEEN ONSET AND DEATH
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 _____, to P _____ and last saw her/him alive on _____
Death occurred at 810 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Patrick T. Taylor Coroner
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 7.8.58.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: JULY 8 1958
23c. NAME OF CEMETERY OR CREMATORY: ST. MATTHEW CEM.
23d. LOCATION (City, town, or county) (State): ST. LOUIS Mo

24. FUNERAL DIRECTOR: Thomas Kutis — ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: JUL 8 '58
26. REGISTRAR'S SIGNATURE: J Earl Smith M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 ..... Signed .....

Signature of Student Embalmer

Not Embalmed

Licensed Embalmer No. 4347

P. O. Address 2906 Gra

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.