

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030931
STATE FILE NUMBER

FILED SEP 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8000

S. 300
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis, Mo.</i>		c. CITY OR TOWN <i>St. Louis, Mo.</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Woodbine Hotel</i>		d. STREET ADDRESS (If outside, give location) <i>4555 Claxton Ave.</i>	
Length of stay in lb <i>31 day</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Frederick T. Schmidt</i>		4. DATE OF DEATH Month <i>8</i> Day <i>16</i> Year <i>58</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 12, 1901</i>
9. AGE (In years last birthday) <i>56</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Accountant</i>	11. BIRTHPLACE (City and state or country) <i>Evansville, Ind.</i>
10b. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>William Schmidt</i>		13b. MOTHER'S MAIDEN NAME <i>Amelia Street</i>	
13c. NAME OF HUSBAND OR WIFE <i>Helen Schmidt</i>		14. NAME OF HUSBAND OR WIFE <i>Helen Schmidt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Helen Schmidt, 4555 Claxton Av.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause of death on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>External Hemorrhage from laceration of arms.</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>E977x</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Do not include conditions given in PART I.) <i>She slipped with razor blades in the bathroom at the Woodbine Hotel, 509 Chestnut St., on August 16th, 1958. exact time unknown.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II.)	
20c. TIME OF INJURY Hour <i>8</i> Month, Day, Year <i>16th, 1958</i> a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Hotel</i>		20f. CITY, TOWN, OR LOCATION <i>St. Louis Mo.</i>	
21. I attended the deceased from Death occurred at <i>8-16-58 2:15 P.</i>		and last saw her/him alive on _____ on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>James M. Kelly</i> (Degree or title) <i>Deputy Emballer</i>		22b. ADDRESS <i>1300 Clark</i>	
22c. DATE SIGNED <i>8-18-58</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>		23b. DATE <i>8-19-58</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis County Mo.</i>	
24. FUNERAL DIRECTOR <i>Drehmann-Harral</i>		25. DATE RECD. BY LOCAL REG. <i>AUG 18 '58</i>	
ADDRESS <i>1905 Union</i>		26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i>	

(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 causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Albert R. Thompson*

Licensed Embalmer No. *4237*
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.