

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011374  
STATE FILE NUMBER  
2536

10-0 MAR 25 1959 Registration District No. Primary Registration District No. Registrar's No.

300  
1-57  
2  
972  
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hosp.</b>		Length of stay in lb <b>3 Days</b>	d. STREET ADDRESS (If outside, give location) <b>4405 Westminster</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Pauline</b> Middle Last <b>Schroder</b>			4. DATE OF DEATH Month <b>3</b> Day <b>10</b> Year <b>1959</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 17, 1874</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William Schroder</b>	13b. MOTHER'S MAIDEN NAME <b>Johanna Hess</b>	14. NAME OF HUSBAND OR WIFE <b>-</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mr. Albert Schroder, 402 Oak Tree Dr.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<b>331x</b>
	DUE TO (c)	
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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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 <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
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21. I attended the deceased from **June 1893** to **3/10/59** and last saw her alive on **3-10-59**  
Death occurred at **11:45** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>H W Hoover M.D.</b>	22b. ADDRESS <b>3720 Washington St. Smith</b>	22c. DATE SIGNED <b>3/12/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>3/14/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethany Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Wellston Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Drehmann-Harral, 1905 Union Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 12 '59</b>	REGISTRAR'S SIGNATURE <b>Robert Smith, M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc., shall use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

115 B

Dr. Henry Noller  
3720 Washington  
Je 3-8498  
Hrs. 9:30-11 A.M. Thurs.

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 *Warren A. Carr* .....

Licensed Embalmer No. *3538* .....

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.