

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019606  
STATE FILE NUMBER

FILED JUN 4 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. 4997

300  
1-57  
495  
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>		c. CITY OR TOWN <b>ST. LOUIS</b>	
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 <b>ALEXIAN BROS. HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>3739 WISCONSIN</b>	
Length of stay in <sup>lb</sup>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>OTTO SCHOFFT</b>			4. DATE OF DEATH Month Day Year <b>MAY 21 1959</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 9 1880</b>
9. AGE (In years last birthday) <b>78</b>	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) <b>RETIRED METAL POLISHER ST. LOUIS PLATING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ST. LOUIS PLATING</b>	11. BIRTHPLACE (City and state or country) <b>GERMANY</b>
12. CITIZEN OF WHAT COUNTRY? <b>U-S-A</b>			
13a. FATHER'S NAME <b>WILLIAM SCHOFFT</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>ELFRIEDA SCHOFFT (DECD)</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>RAYMOND SCHOFFT 3976 WALSH</b>
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>Coronary vascular heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>9 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <b>422.1</b>			
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 type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK <input type="checkbox"/> NOT WHILE 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
21. I attended the deceased from <b>10-24-50</b> to <b>5-21-59</b> and last saw him alive on <b>5-21-59</b> Death occurred at <b>5-21-59 9:45 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John D. Sertling M.D.</b> (Degree or title)		22b. ADDRESS <b>3739 Gravois</b>	22c. DATE SIGNED <b>5-22-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>MAY 23 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MISSOURI CREMATORY</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>
24. FUNERAL DIRECTOR <b>Thomas Kutis 2906 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 23 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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

mrs

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 Howard C. Hill .....

Licensed Embalmer No. 4347 .....  
P. O. Address 2906 Fido .....

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.