

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS OCT 8 1959

59-034305

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 8837** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 20 years		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4714 Tamm Avenue				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4714 Tamm Avenue	
3. NAME OF DECEASED (Type or print) First Ray Middle Joseph Last Schurter			4. DATE OF DEATH Month September Day 23 Year 1959				
5. SEX Male	6. COLOR OR RACE Caucasian	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/19/1897	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician-Surgeon		10b. KIND OF BUSINESS OR INDUSTRY Medicine (M.D.)		11. BIRTHPLACE (City and state or country) Mildmay Ontario, Canada		12. CITIZEN OF WHAT COUNTRY USA (Nat'l)	
13a. FATHER'S NAME Charles Schurter			13b. MOTHER'S MAIDEN NAME (unknown)		14. NAME OF HUSBAND OR WIFE Rosamond Schurter		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 494-36-7310		17. INFORMANT Address Mrs. R. J. Schurter, 4717 Tamm Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidermoid carcinoma, primary site undetermined, probably of lung, with metastases to rib, cervical lymph nodes. DUE TO (b) lymph nodes. DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 8 mo. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Tuberculosis M.A. Inactive					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 WORK <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	
21. I attended the deceased from 2-27-59 , to 8-10-59 and last saw her/him alive on 8-10-59 Death occurred at 11:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Bernard Friedman, M.D.				22b. ADDRESS Koeh Hospital, Kosh, Mo		22c. DATE SIGNED 9-25-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9/26/1959		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
24. FUNERAL DIRECTOR ADDRESS Hoffmeister Colonial Mortuary 6464 Chippewa Street, St. Louis, Mo.				25. DATE RECD. BY LOCAL REG. SEP 25 '59		26. REGISTRAR'S SIGNATURE Earl Smith, M.D. <i>m B B</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Gene C. Branson*

Licensed Embalmer No. 4768

P. O. Address St. Louis, Mo.

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.