

**URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS FEB 25 1960**

**2 1664**

~~60-008838~~  
 STATE FILE NUMBER  
**60-008838**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Parklane Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3935 Walsh St.</b>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>C.</b> Last <b>SCHRAMM</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>12</b> Year <b>1960</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>9-12-1909</b>	9. AGE (last birthday) <b>50</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator - Grove Laboratories</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis, Mo.</b>	11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME <b>Richard P. Schramm</b>	13b. MOTHER'S MAIDEN NAME <b>Katherine Craycroft</b>	14. NAME OF HUSBAND OR WIFE -----
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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. <b>None</b>	17. INFORMANT <b>Katherine Gross 3935 Walsh St.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>acute broncho pneumonia</b> DUE TO (b) <b>acute broncho pneumonia</b> DUE TO (c) <b>491x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Heart Disease</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____	Month _____ Day _____ Year _____
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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.) <b>@ 11:30 AM</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo.</b>
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21. I attended the deceased from <b>4:20 A. 5/11/60</b> to <b>5/11/60</b> and last saw her/him alive on <b>5/11/60</b> . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>A. C. Males</b> (Degree or title) <i>(A. C. Males, M.D.)</i>	22b. ADDRESS <b>505 University Club Bldg.</b> <i>505 University Club Bldg.</i>	22c. DATE SIGNED <b>5/11/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 15, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 13 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

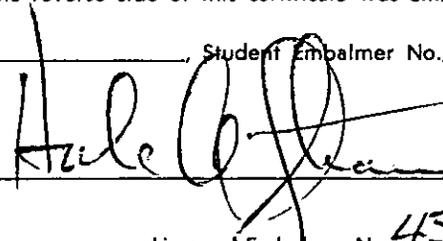
BY AFFIDAVIT OF

**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



Licensed Embalmer No. 4533

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.