

FEDERAL BUREAU OF INVESTIGATION
FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009408

FILED VS MAR 1 0 1960

317

Registration District No.

Primary Registration District No.

500

Registrar's No.

447

STATE FILE NUMBER

UNDECEASED

| | | | | | | | | | |
|---|--|--|--|--|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY ST. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LEMAY | | Length of stay in 1b DAYS. | | 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 MARYRIDGE CONVALESCENT | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3330 LEMP | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE WERNER-SCHMITT | | | | 4. DATE OF DEATH Month Day Year Feb 9 1960 | | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 2-20-1890 | | 9. AGE (last birthday) 79 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME CONRAD KURZ | | | 13b. MOTHER'S MAIDEN NAME UNKNOWN | | | 14. NAME OF HUSBAND OR WIFE HENRY SCHMITT (Dec'd) | | | |
| 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. None | | 17. INFORMANT Address Edwin WERNER 6978 LANDSDOWNE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 38 days | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension and arteriosclerosis | | | | | | | 4 yrs. | | |
| DUE TO (c) arterio sclerotic heart disease & Arteriosclerosis & yr. | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0 | | | | | | 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 | | | |
| 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 Jan 12 1960 to Feb 9 1960 and last saw her alive on Feb 9 1960 Death occurred at 12 35 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) May Staff MD | | | | 22b. ADDRESS 512 Dow Place | | | 22c. DATE SIGNED 2/10/60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE Feb 12, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY MT. Olive Cem. | | 23d. LOCATION (City, town, or county) (State) ST. LOUIS, Co. Mo. | | | |
| 24. FUNERAL DIRECTOR ADDRESS Thomas Kutis 2906 Brown | | | 25. DATE RECD. BY LOCAL REG. 2-11-60 | | 26. REGISTRAR'S SIGNATURE [Signature] | | | | |

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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grand

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.