

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS SEP 2 1960

-60-032836  
 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8298

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in Tb		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>3539 Sidney</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>B</u> Last <u>SCHULTE</u>			4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1960</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/1872</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Keokuk, Iowa</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>John A Essig</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara Schwan</u>	
14. NAME OF HUSBAND OR WIFE <u>Carl E.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Herbert Schulte</u>		Address <u>5006a Tholozan</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA LOBAR ATYPICAL RT. UPPER</u>		INTERVAL BETWEEN ONSET AND DEATH <u>22 DAYS</u>
DUB TO (b) <u>FRACTURE OF FEMUR RT TROCHANTERIC</u>		<u>9 DAYS</u>
DUE TO (c) <u>9000-21</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal condition given in PART I <u>DUODENAL ULCER - RUPTURED</u>		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	
<u>HYPERTENSIVE ARTERIOSCLEROTIC</u>		<u>CARDIOVASCULAR RENAL SYND.</u>	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input checked="" 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.) <u>FELL DOWN 8 STAIRS AT HOME 8/14/60</u>
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20c. TIME OF INJURY Hour <u>10</u> Month, Day, Year <u>8-14-60</u> p.m.
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>AT Home</u>	20f. CITY, TOWN, OR LOCATION <u>ST LOUIS</u>	COUNTY <u>Mo</u>	STATE <u>Mo</u>
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21. I attended the deceased from <u>8-15-60</u> to <u>8-23-60</u> and last saw her <u>relative</u> on <u>8/22/60</u>
Death occurred at <u>7:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Edward J. Braun M.D.</u>	(Degree or title)	22b. ADDRESS <u>2838 Acacia Blvd.</u>	22c. DATE SIGNED <u>8-23-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>8/25/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	23d. LOCATION (City, town, or County) (State) <u>St. Louis County, Mo.</u>
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24. FUNERAL DIRECTOR <u>John L Ziegenhein &amp; Sons 7027 Gravois</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>AUG 23 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith. M.D.</u>
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Arnold Benz

Licensed Embalmer No. 486  
P. O. Address St Louis

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