

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-035839

FILED VS OCT 13 1960

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 198

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>				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. Charles</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		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>St. Josephs Hosp St. Charles Mo.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4471 Olive</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>JOHN SCHADT</b> First Middle Last				4. DATE OF DEATH <b>Oct. 2 1960</b> Month Day Year					
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>9/22/1869</b>		9. AGE (last birthday) <b>91</b> IF UNDER 1 YEAR IF UNDER 24 HR Months <b>0</b> Days <b>10</b> Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Fitter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and state or country) <b>Ft. Madison Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13a. FATHER'S NAME <b>Unknown Schadt</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Emma Schadt</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. <b>UNKNOWN.</b>		17. INFORMANT Address <b>Mrs. John Shannahan 1935 Brown Rd.</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>Pneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>being bedridden</b>							
		DUE TO (c) <b>intertrochanteric fracture left femur</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							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 a.m. p.m.		Month, Day, Year							
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 <b>9-12-60</b> to <b>10-1-60</b> and last saw <input checked="" type="checkbox"/> alive on <b>10-1-60</b> Death occurred at <b>2:30 AM 10-2-60</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Arne E. Carlson M.D.</b>				22b. ADDRESS <b>3109 Brown Rd. 14</b>			22c. DATE SIGNED <b>10-3-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10/4/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>C.R. Lupton and Sons 7233 Delmar</b>				25. DATE RECD. BY LOCAL REG. <b>10-8-60</b>		26. REGISTRAR'S SIGNATURE <b>Marella Wilson</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 14 1960

*John Sebatt*  
*Harrisville Clinic (Sr. Embalmer No.)*

**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 W. Scho*

Licensed Embalmer No. *386*

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.