SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-006887
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1427

FILED VS FEB 20 1961

DATE AMENDED 12-

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST LOUIS
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: D.O.A ST. JOHNS HOSP
Inside Limits Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location): 4755 BONITA
Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First MIKE Middle Last SCHMITZ
4. DATE OF DEATH: Month FEB Day 9 Year 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married X Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2/22/1885
9. AGE (last birthday): 75
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GROCER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): AUSTRIA HUNGARY
12. CITIZEN OF WHAT COUNTRY: U-S-A.
13a. FATHER'S NAME: FRED SCHMITZ
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE: KATIE SCHMITZ
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: KATIE SCHMITZ Address: 4755 BONITA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 Minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROTIC HEART DISEASE — 10 Years
DUE TO (c): 4200
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO X
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 JUNE 1950 to 2/9/61 and last saw ~~her~~ him alive on 2/1/61
Death occurred at 1:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John J Hennelly (Degree or title) MD.
22b. ADDRESS: 6200 CHIPPEWA
22c. DATE SIGNED: 2/10/61

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: FEB 13. 1961
23c. NAME OF CEMETERY OR CREMATORY: SUNSET BURIAL PARK
23d. LOCATION (City, town, or county): ST. LOUIS Co (State): MO.
24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: FEB 12 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1-5 Fri
9-17-Sat

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Samuel C Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Drau

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.