

318

1003

-61-006889

STATE FILE NUMBER

AMENDED

Registration District No. **FILED VS FEB 28 1961**

Primary Registration District No.

Registrar's No.

1575

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

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>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. ANTHONY HOSPITAL</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2861<sup>o</sup> TEXAS AVE</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>SCHNETZER</b> Last				4. DATE OF DEATH Month <b>FEB</b> Day <b>13</b> Year <b>1961</b>			
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>FEB 3, 1908</b>	9. AGE (last birthday) <b>53</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROOF READER SERVICE BLUE PRINT CO</b>	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>		
13a. FATHER'S NAME <b>PETER SCHNETZER</b>			13b. MOTHER'S MAIDEN NAME <b>MINNIE ALBRICHT</b>		14. NAME OF HUSBAND OR WIFE		
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.		17. INFORMANT <b>MARY KRAUS 2861<sup>o</sup> TEXAS AVE</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>Metastatic Neoplasm Distal Col at</b> <b>Crossing Pt. Great</b> <b>with cerebral involvement</b> DUE TO (b) <b>1 1/2 yrs</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
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. <b>170x</b> <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.) <b>170x</b>			
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>Jan. 12, 1960</b> to <b>Feb. 13, 1961</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>Feb. 13, 1961</b> Death occurred at <b>8 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>[Signature]</b> (Degree or title)				22b. ADDRESS <b>3606 [Address]</b>		22c. DATE SIGNED <b>2/15/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>FEB 17, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO.</b>		
24. FUNERAL DIRECTOR <b>Thomas Katis 2906 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 16 1961</b>		26. REGISTRAR'S SIGNATURE <b>[Signature] M.D.</b>			

**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 Rocky Thompson

Licensed Embalmer No. 4861

P. O. Address Clayton 5, N.C.

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.