

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

3943

-61-015606

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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. CITY OR TOWN **Richmond Hts.** Inside Limits Yes No
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **St. John's Hospital** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **7363 Goff Ave.** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **CORINNE** Middle **F.** Last **SCHERMEN** 4. DATE OF DEATH Month **Apr.** Day **24** Year **1961**

5. SEX **Female** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **1-9-1904** 9. AGE (last birthday) **57**
 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) **Housework** 10b. KIND OF BUSINESS OR INDUSTRY **At Home** 11. BIRTHPLACE (City and state or country) **St. Louis, Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME _____ 13b. MOTHER'S MAIDEN NAME **Mattie F. Stevens** 14. NAME OF HUSBAND OR WIFE **Joseph F. Schermen**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** (If yes, give war or dates of service) **None** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT **Joseph F. Schermen** Address **7363 Goff Ave.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Uremia**
 DUE TO (b) **Polycystic Kidney Dis.**
 DUE TO (c) **7571**
 INTERVAL BETWEEN ONSET AND DEATH **2 mos**

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 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 **1958** to **9-24-61** and last saw her/him alive on **9-24-61**
 Death occurred at **1:30 P.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **W. S. Kuntz MD** (Degree or title) 22b. ADDRESS **950 Franklin St.** 22c. DATE SIGNED **9-25-61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **Apr. 27, 1961** 23c. NAME OF CEMETERY OR CREMATORY **Resurrection Cemetery** 23d. LOCATION (City, town, or county) (State) **St. Louis County, Mo.**

24. FUNERAL DIRECTOR **Kriegshauser** ADDRESS **4228 S. Kingshighway Blvd.** 25. DATE RECD. BY LOCAL REG. **APR 25 1961** 26. REGISTRAR'S SIGNATURE **Earl Smith, M.D.**

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Ernest W. Spilla

Licensed Embalmer No. 4080

P. O. Address _____

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.