

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-016033**

STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 965

**FILED APR 17 1961**

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bellefontaine Neighbors</u>		c. CITY OR TOWN <u>Ballwin, Mo.</u>	
Length of stay in 1b <u>3 mos. 2 fda</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis State School and Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>111 Maple Lane</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Frances Schroeder</u>			4. DATE OF DEATH Month Day Year <u>4 6 1961</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-49</u>
9. AGE (last birthday) <u>11 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Wilfred Russell Schroeder</u>	
13b. MOTHER'S MAIDEN NAME <u>Helen ReKosz</u>		14. NAME OF HUSBAND OR WIFE <u>—</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>—</u>	
17. INFORMANT <u>Records of St. Louis State Sch. &amp; Hosp. 10695 Bellefontaine Rd.</u>		Address	
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>Broncho-pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Measles</u>			<u>3 days</u>
DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Encephalitis, Epilepsy - Mental Deficiency</u>			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 checked="" type="checkbox"/> NO <input 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 <u>12-9-60</u> to <u>4-6-61</u> and last saw him alive on <u>4-6-61</u> Death occurred at <u>8:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dorothy M. Ellersick M.D.</u>		22b. ADDRESS <u>10695 Bellefontaine Rd.</u>	22c. DATE SIGNED <u>4-6-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-10-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Schrader Funeral Home Ballwin, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-8-61</u>	26. REGISTRAR'S SIGNATURE <u>John W. Murphy M.D.</u>

**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

*Richard Bopp*

Licensed Embalmer No. 4584

P. O. Address Ballerwin, Mo.

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.