

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016034

AMENDED

Filed APR 24 1961

Primary Registration District No. 500 Registrar's No. 1061

STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>St. Louis</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>St. Louis</i> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Manchester Mo.</i> | | Length of stay in 1b <i>1 month</i> | c. CITY OR TOWN Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Pine Crest Nursing Home</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <i>9326 Scottdale</i> |
| 3. NAME OF DECEASED (Type or print) First <i>Edelyn Lois</i> Middle <i>Schulte</i> Last <i>Schulte</i> | | 4. DATE OF DEATH Month <i>4</i> Day <i>16</i> Year <i>1961</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <i>3/29/55</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>NONE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i> | 9. AGE (last birthday) <i>6yr</i> IF UNDER 1 YEAR: Months <i>6</i> Days <i>0</i> IF UNDER 24 HR: Hours <i>0</i> Min. <i>0</i> |
| 11a. BIRTHPLACE (City and state or country) <i>St. Louis</i> | | 12. CITIZEN OF WHAT COUNTRY <i>USA</i> | |
| 13a. FATHER'S NAME <i>Erving Schulte</i> | | 13b. MOTHER'S MAIDEN NAME <i>Geraldine Baiter</i> | 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) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT <i>Father - 9326 Scottdale</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Status Epilepticus</i> DUE TO (b) <i>Cerebral Palsy</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <i>8 hours since birth</i> |
| 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 checked="" 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"/> <i>None</i> | 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 <i>3-25-61</i> to <i>4-16-61</i> and last saw her <i>alive</i> on <i>4-4-61</i> Death occurred at <i>4-16-61 1:30</i> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <i>Allen McQuarney M.D.</i> | | 22b. ADDRESS <i>4308 Epiter</i> | 22c. DATE SIGNED <i>4-18-61</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 23b. DATE <i>4-19-61</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>BETHLEHEM CEM.</i> | 23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i> |
| 24. FUNERAL DIRECTOR <i>Buechholz Mort. 5967 W. Florissant Ave</i> | 25. DATE RECD. BY LOCAL REG. <i>4-18-61</i> | 26. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i> | |

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 _____

Licensed Embalmer No. _____

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.