

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **905E** **61-034894** STATE FILE NUMBER

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>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>36 Yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4710 Farlin</b>		d. STREET ADDRESS (If outside, give location) <b>4710 Farlin Ave.</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle Last <b>Schaub</b>			4. DATE OF DEATH Month <b>9</b> Day <b>30</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-20-76</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supply Buyer (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sligo Iron Co.</b>	11. BIRTHPLACE (City and state or country) <b>- Germany</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Jacob Schaub</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine (Unknown)</b>		14. NAME OF HUSBAND OR WIFE <b>Mathilda Schaub</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			17. INFORMANT Address <b>4710</b> <b>Mrs. Mathilda Schaub, Farlin</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
IMMEDIATE CAUSE (a) <b>Coronary Occlusion, acute</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arterio-sclerotic Cardio</b>	
DUE TO (c) <b>Cardiac failure, compensated</b>		<b>over 3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>none</b>		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 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>4201</b>
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20c. TIME OF INJURY Hour <b>10:15 PM</b> Month, Day, Year <b>30 Sept 61</b>	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 <b>St. Louis</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>30 June 58</b> to <b>30 Sept 61</b> and last saw <b>her</b> alive on <b>13 Sept 61</b> Death occurred at <b>10:15 PM 30 Sept 61</b> on the date stated above, and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE <b>Edward M. Smith, MD</b>	(Degree or title)	22b. ADDRESS <b>116 1/2 So 7101 1/2 Sant Rd.</b>	22c. DATE SIGNED <b>30 Sept 61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>10-3-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Lucas Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>

24. FUNERAL DIRECTOR <b>Drehmann-Harral, 1905 Union Blvd.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>OCT 2 1961</b>	26. REGISTRAR'S SIGNATURE <b>Edward M. Smith, M.D.</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

Dr. Eugene Hall  
116a S. Florissant Rd.  
Ja 1-0907

**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 Albert R. Thompson

Licensed Embalmer No. H-237

P. O. Address H. Lewis

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.