

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH - 81-034898

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8152 STATE FILE NUMBER

FILED SEP 18 1961

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> , b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b | c. CITY OR TOWN <u>St. Louis</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>3112 Mt. Pleasant St.</u> |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>J.</u> Last <u>Schiele</u> | 4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1961</u> |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/20/1894</u> | 9. AGE (last birthday) <u>66</u> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Setup Man-Alton Paper Box Co.</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired 6 Months</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>John Schiele</u> | 13b. MOTHER'S MAIDEN NAME <u>Sophia Balven</u> | 14. NAME OF HUSBAND OR WIFE <u>Clara Schiele</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW-1</u> | 17. INFORMANT Address <u>Mrs. Clara Schiele, 3112 Mt. Pleasant St.</u> |
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| 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>Transitional Ca. of Urinary Bladder in IV</u> | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | |

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| 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 type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month _____ Day _____ Year _____ |
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| 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 _____ |
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| 21. I attended the deceased from <u>5-1-60</u> to <u>8-31-61</u> and last saw her/him alive on <u>8/31/61</u> Death occurred at <u>6:00 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <u>L. M. Cronberg M.D.</u> (Degree or title) | 22b. ADDRESS <u>4652 Maryland</u> | 22c. DATE SIGNED <u>9/1/61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Sept. 4, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u> |
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| 24. FUNERAL DIRECTOR <u>Gebken-Benz Mortuary</u> | ADDRESS <u>2842 Meramec St. St. Louis, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>SEP 1 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Roal Smith M.D.</u> |
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DATE AMENDED
INSTEAD OF
ITEM NO. SHOULD READ
BY AFFIDAVIT OF

DOCUMENT
MEDICAL CERTIFICATION

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

Herbert J. Gau Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 277

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.