SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-035453
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2630

FILED SEP 29 1961

1. PLACE OF DEATH
a. COUNTY ST LOUIS,
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN COOL VALLEY — Length of stay in 1b 15 DAYS
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) HILL TOP NURSING HOME 1308 SO FLORISSANT RD — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY
c. CITY OR TOWN ST LOUIS — Inside Limits Yes XX No ☐
d. STREET ADDRESS (If outside, give location) ALVERNE HOTEL 10th & LOCUST ST. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First ALBIN Middle W. Last SCHMIDT
4. DATE OF DEATH Month SEPT, Day 16, Year 1961

5. SEX MALE
6. COLOR OR RACE WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH SEPT, 21, 1873
9. AGE (last birthday) 87 — 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) RETIRED PRINTER
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) GLASGOW MISSOURI
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME WILLIAM SCHMIDT
13b. MOTHER'S MAIDEN NAME UNKNOWN
14. NAME OF HUSBAND OR WIFE JOSEPHINE SCHMIDT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address RALPH SCHMIDT 1035 GABRIEL BELLEFONTAINE NEIGHBORS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH -?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 450.0
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 Aug 13 - 1961, to Sept 16 - 1961 and last saw him alive on Sept 15 - 1961
Death occurred at 5:05 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John G. McTurney MD
22b. ADDRESS 5014 Thekla Av
22c. DATE SIGNED 9/18/61

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 9/19/61
23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY
23d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI

24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE
25. DATE RECD. BY LOCAL REG. 9-18-61
26. REGISTRAR'S SIGNATURE John C. Murphy MD

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED 9-2
INSTEAD OF
SHOULD READ
ITEM NO.
DOCUMENT
BY AFFIDAVIT OF

McGinnis
5074 Theb
Jo 54688
10 30 am

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 M W Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis, M

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.