

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039193  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318 1003 9732  
Registration District No. Primary-Registration District No. Registrar's No.

AMENDED  
FILED NOV 8 1961

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>		Length of stay in 1b	c. CITY OR TOWN <b>ST. LOUIS</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LUTHERAN HOSP.</b>		Inside Limits <input type="checkbox"/> Yes <input type="checkbox"/> No	d. STREET ADDRESS (If outside, give location) <b>3017<sup>a</sup> McNAIR</b>

3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD SCHROEDER</b>			4. DATE OF DEATH Month Day Year <b>OCT. 10, 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>DEC. 26, 1908</b>	9. AGE (last birthday) <b>52</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done or the most of working life, even if retired) <b>BEER BOTTLER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUSCH BREWERY</b>	11. BIRTHPLACE (City and state or country) <b>MO. U.S.A.</b>	12. CITIZEN OF WHAT COUNTRY	

13a. FATHER'S NAME <b>NICHOLAS SCHROEDER</b>	13b. MOTHER'S MAIDEN NAME <b>NELLIE REARDON</b>	14. NAME OF HUSBAND OR WIFE <b>GRACE SCHROEDER</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>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>GRACE SCHROEDER</b> Address <b>3017<sup>a</sup> McNAIR</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
IMMEDIATE CAUSE (a)	<b>Cerebral apoplexy, right anterior</b>	
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.	<b>fossa; Chronic myocarditis</b>	
DUE TO (b)		
DUE TO (c)		<b>334-X</b>

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 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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **2:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Paul J. Simon</b> (Degree or title) <b>Deputy Coroner</b>	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>10/21/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>OCT. 23 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PETER + PAUL</b>	23d. LOCATION (City, town, or county) <b>ST. LOUIS</b>	(State) <b>MO.</b>
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24. FUNERAL DIRECTOR <b>Thomas Huetin</b> ADDRESS <b>2906 GRAVOIS</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 23 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Eleanor Bonine

Licensed Embalmer No. 3403

P. O. Address 2906 Grover

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.