SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-042868
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11381

FILED DEC 12 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: MOTHER OF PERPETUAL HELP
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO. b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3419 GASCONADE
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First LENA Middle Last SCHNEIDER
4. DATE OF DEATH Month DEC Day 5 Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: APRIL 5 1873
9. AGE (last birthday): 88
IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (City and state or country): ILL.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: JOHN SCHNEIDER
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE:
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: OSCAR MUELLER Address: 3725 VIRGINIA

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): Acute heart failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c): Senility 420.0
INTERVAL BETWEEN ONSET AND DEATH
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 1950 to 1961 and last saw her/him alive on 12-4-61
Death occurred at 12-6-61 8 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) MD
22b. ADDRESS: 1703 S. Grand
22c. DATE SIGNED: 12-6-61

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: DEC 7 1961
23c. NAME OF CEMETERY OR CREMATORY: RESURRECTION
23d. LOCATION (City, town, or county) (State): ST. LOUIS CO. MO

24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: DEC 7 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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

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. 4347

P. O. Address 2906

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.