

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046832

FILED DEC 18 1961

318

1003

11468

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

AMENDED -

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>	Length of stay in 1b	c. CITY OR TOWN <i>ST. LOUIS</i>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>2350 S. 11th St</i>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>2350 S. 11th St</i>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>BARBARA</i> Middle <i>SCHLECHT</i> Last	4. DATE OF DEATH Month <i>DEC.</i> Day <i>6</i> Year <i>1961</i>
---	---

5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 31 1874</i>	9. AGE (last birthday) <i>87</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-------------------------	----------------------------------	---	--	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WORK</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	11. BIRTHPLACE (City and state or country) <i>Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
--	---	---	--

13a. FATHER'S NAME <i>ALBERT CHOTT</i>	13b. MOTHER'S MAIDEN NAME <i>MARY KADLETZ</i>	14. NAME OF HUSBAND OR WIFE <i>ROBERT SCHLECHT</i>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>ROSE HINCK</i>	Address <i>2350 S 11th</i>
---	--	------------------------------------	-------------------------------

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)	<i>Quarrelous fibrillation</i>	<i>2 weeks</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Chr myoearditis</i>	<i>8 yrs</i>
	DUE TO (c) <i>4.3.31.</i>	

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 checked="" 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.)
---	---	--

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 <i>May 18</i> to <i>12/6/61</i> and last saw her alive on <i>12/5/61</i>	Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
---	--

22a. SIGNATURE <i>J. W. Deworel M.D.</i>	(Degree or title)	22b. ADDRESS <i>2026 So 9th St</i>	22c. DATE SIGNED <i>12/8/61</i>
---	-------------------	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>DEC. 9 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>SUNSET BURIAL PK</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>
---	---------------------------------	---	--

24. FUNERAL DIRECTOR <i>Thomas Kuth 2906 Lewis</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>DEC 8 1961</i>	26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>
---	---------	---	---

BY AFFIDAVIT OF

STANDARD RECORD

*P. H. Russell
Embalmer*

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 *James C. Gill*

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.