ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

ITMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER: -61-047386

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3355

FILED DEC 21 1961

AMENDED

DATE AMENDED 92

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: KOCH MO — Length of stay in 1b: 47 days
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ROBT KOCH HOSP — 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): 1930 SALISBURY — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: ALBERT Middle: Last: SCHREIBER

4. DATE OF DEATH: Month: NOV Day: 27 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3-18-89
9. AGE (last birthday): 72 — 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): BARTENDER
10b. KIND OF BUSINESS OR INDUSTRY: Salisbury Halls
11. BIRTHPLACE (City and state or country): ST LOUIS MO
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: FRED SCHREIBER
13b. MOTHER'S MAIDEN NAME: ~~EMILY~~ Minnie Stollhort
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)

17. INFORMANT: Hospital Recd. Address: Robt Koch Hosp

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL ARTERY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 month
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 332+

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): ABSCESS Subcut Tissue region L. gtr Trochanter

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 Oct 11 1961, to Nov 27/61 and last saw ~~her~~ him alive on Nov 27 1961
Death occurred at 3 25 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Frank Cohen MD
22b. ADDRESS: Robert Koch Hosp KOCH MO
22c. DATE SIGNED: 11/27/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11-29-61
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Mo

24. FUNERAL DIRECTOR: Edw Koch + Son — ADDRESS: 3516 N. 14th
25. DATE RECD. BY LOCAL REG.: 11-27-61
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed Herbert J. Gau Jr.

Signature of Student Embalmer

Licensed Embalmer No. 4800

P. O. Address Kirkwood 27, Mo

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.