

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017232

4234

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

**FILED MAY 1 1962**

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>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)<br>HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>5820 Nottingham Ave.</b>          |
|  |  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Marie</b> Middle <b>B.</b> Last <b>Schmitz</b> | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>23</b> Year <b>1962</b> |
|--|---|

|                         |                                  |   |  |                                     |                                |                              |
|-------------------------|----------------------------------|---|--|-------------------------------------|--------------------------------|------------------------------|
| 5. SEX<br><b>Female</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 12, 1892</b> | 9. AGE (last birthday)<br><b>69</b> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|-------------------------|----------------------------------|---|--|-------------------------------------|--------------------------------|------------------------------|

|   |   |   |  |
|---|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b> | 11. BIRTHPLACE (City and state or country)<br><b>ST. Louis, Mo.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b> |
|---|---|---|--|

|  |   |  |
|--|---|--|
| 13a. FATHER'S NAME<br><b>unknown McAndrews</b> | 13b. MOTHER'S MAIDEN NAME<br><b>unknown</b> | 14. NAME OF HUSBAND OR WIFE<br><b>ERWIN A. Schmitz</b> |
|--|---|--|

|   |                         |   |
|---|-------------------------|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO. | 17. INFORMANT<br><b>Betty Reed 1210 San Jacinto St.</b> |
|---|-------------------------|---|

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the left ovary with metastases</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>19 mos</b> |
| DUE TO (b) <b>metastases</b>   |  |   |
| DUE TO (c) <b>1750</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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
|---|--|---|

|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 **1954** to **April 24, 1962** and last saw her <sup>him</sup> alive on **April 23, 1962**.  
Death occurred at **12:40 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                   |   |                                    |
|--|-------------------|---|------------------------------------|
| 22a. SIGNATURE<br><b>Herbert C. Megard, M.D.</b> | (Degree or title) | 22b. ADDRESS<br><b>3720 Washington Blvd. St. Louis 8, Mo.</b> | 22c. DATE SIGNED<br><b>4/24/62</b> |
|--|-------------------|---|------------------------------------|

|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b> | 23b. DATE<br><b>Apr. 26, 1962</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Valhalla Crematory</b> | 23d. LOCATION (City, town, or county)<br><b>ST. Louis, Co., Mo.</b> |
|---|-----------------------------------|---|---|

|  |                                |  |  |
|--|--------------------------------|--|--|
| 24. FUNERAL DIRECTOR<br><b>Witt Mortuary</b> | ADDRESS<br><b>6409 Gravois</b> | 25. DATE RECD. BY LOCAL REG.<br><b>APR 24 1962</b> | 26. REGISTRAR'S SIGNATURE<br><b>Loal Smith, M.D.</b> |
|--|--------------------------------|--|--|

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**58**

**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 *John J. Haines*  
Licensed Embalmer No. 4108

P. O. Address *Shenick*

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.

*Herbert Wingard*