

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017242  
STATE FILE NUMBER

318 / Primary Registration District No. 1003 Registrar's No. 4397

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_

**FILED MAY 10 1962**

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP.#1</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>3739 MINNESOTA AVE</b>			(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>OTTO A SCHULTZ</b>			4. DATE OF DEATH Month Day Year <b>APRIL 27 1962</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>AUG 5, 1884</b>		9. AGE (last birthday) <b>77</b>		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) <b>RETIRED LABORER</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>RUMA ILL</b>		12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>		
13a. FATHER'S NAME <b>WILLIAM SCHULTZ</b>			13b. MOTHER'S MAIDEN NAME <b>SOPHIA KUHLMANN</b>			14. NAME OF HUSBAND OR WIFE <b>SELMA SCHULTZ</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. <b>NONE</b>		17. INFORMANT Address <b>OTTO B. SCHULTZ 2001 WITHNELL ST</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic Heart Disease</b> DUE TO (b) <b>General arteriosclerosis</b> DUE TO (c) <b>420.0.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									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. <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 <b>4-7-62</b> to <b>4-27-62</b> and last saw <sup>for</sup> him alive on <b>4-27-62</b> Death occurred at <b>1:35 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Robert L. Malench, M.D.</b> (Degree or title)				22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>			22c. DATE SIGNED <b>4/27/62</b>		
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE <b>APR 30 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MATTHEW CEM</b>		23d. LOCATION (City, town, or county) <b>ST. LOUIS</b>		(State) <b>MO</b>	
24. FUNERAL DIRECTOR <b>Thomas Nutis 2906 Gravois</b>				25. DATE RECD. BY LOCAL REG. <b>APR 30 1962</b>		25. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

VS 300 Rev. 4/59  
 1  
 2 **216**  
 3  
 4 **0**  
 5 **1**  
 6  
 7 **1**  
 8 **2**  
 9  
 10  
 11  
 12 **75-0**  
 13  
**75**

Robert L. Malench, M.D.  
 USE BLACK INK  
 OR  
 TYPEWRITER RIBBON

**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,

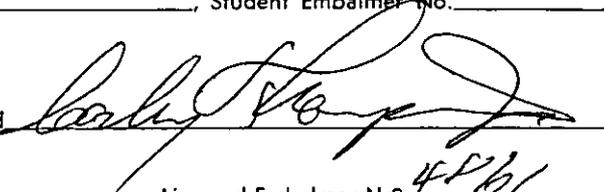
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 48861

P. O. Address Way 5 Me

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.