

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10359**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 128 days		6. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hospital				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1111 S. 12th St.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Fannie Schuessler						4. DATE OF DEATH Month Day Year 10 28 62		5. SEX Female		6. COLOR OR RACE White	
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2/10/1883		9. AGE (last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11a. BIRTHPLACE (City and state or country) Austria				11b. BIRTHPLACE (City and state or country) U-S-A				12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME John KNAPP	
13b. MOTHER'S MAIDEN NAME Barbara				13c. NAME OF HUSBAND OR WIFE ANDREW SCHUESSLER				14. NAME OF HUSBAND OR WIFE ANDREW SCHUESSLER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE				17. INFORMANT ANDREW SCHUESSLER 1111 S. 12th ST				Address		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 Myocardial Failure						INTERVAL BETWEEN ONSET AND DEATH 24 Hours		DUE TO (b)	
DUE TO (c)		Coronary Arteriosclerotic Heart Disease						DUE TO (b)		DUE TO (c)	
DUE TO (b)		420.0						DUE TO (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Decubiti - ARTHRITIS								PART III. If deceased <input checked="" type="checkbox"/> as 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 e.m. Month, Day, Year p.m.		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 6/22/62 to 10/28/62 and last saw her/him alive on 10/28/62 Death occurred at 11:05 AM m on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE John J. Keeney, M.D. (Degree or title)		22b. ADDRESS 5800 Arsenal Ave		22c. DATE SIGNED 10-29-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE OCT 31 1962		23c. NAME OF CEMETERY OR CREMATORY CONCORDIA CEM.		23d. LOCATION (City, town, or county) ST. LOUIS		23e. STATE MO.			
24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois ADDRESS				25. DATE RECD. BY LOCAL REG. OCT 29 1962		26. REGISTRAR'S SIGNATURE Loard Smith, M.D.					

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR OR TYPEWRITER RIBBON

SHOULD READ

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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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Province

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.