

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044837

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11021**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED **1**

FILED NOV 9 6 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT

ITEM NO. SHOULD READ

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Saint Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis | | c. CITY OR TOWN University City | |
| Length of stay in 1b | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda General Hospital | | d. STREET ADDRESS 570 Bedford Ave (If outside, give location) | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARIE Middle M. Last SCHOENHERR | | | 4. DATE OF DEATH Month November Day 15 Year 1962 |
| 5. SEX female | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3/5/1877 |
| 9. AGE (last birthday) 85 | | 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) nurse | | 10b. KIND OF BUSINESS OR INDUSTRY nursing | 11. BIRTHPLACE (City and state or country) Chicago, Ill |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Ernest W. Schoenherr | |
| 13b. MOTHER'S MAIDEN NAME Mary Smith | | 14. NAME OF HUSBAND OR WIFE _____ | |
| 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 Robert W. Harris | | Address 10250 Bauer Rd St. L, 23, MO | |
| 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 Hemorrhage | | | MO. INTERVAL BETWEEN ONSET AND DEATH 6 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis | | | unknown |
| DUE TO (c) Arteriosclerotic Heart Dis | | | unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0 | | | 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 checked="" 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 11/9/1962 to 11/15/1962 and last saw her alive on 11/15/1962 Death occurred at 10:15 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Thomas F. Fisher M.D. (Degree or title) | | 22b. ADDRESS 4660 Mainland | 22c. DATE SIGNED 11/16/62 |
| 22b. ADDRESS St. Louis, Mo. | | 22c. DATE SIGNED _____ | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) entombment | 23b. DATE 11/19/62 | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum | 23d. LOCATION (City, town, or county) St. Louis County Mo. |
| 24. FUNERAL DIRECTOR Lupton Chapel, Inc 7233 Delmar Blvd ADDRESS | | 25. DATE RECD. BY LOCAL REG. NOV 16 1962 REGISTRAR'S SIGNATURE Robert W. Harris M.D. | |

USE BLACK INK OR TYPEWRITER RIBBON

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W. H. Hines W. Barber
4660 Maryland
No. 3-1813

Arnold W. Schoene

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 *Arnold W. Schoene*

Licensed Embalmer No. 3864

P. O. Address St. Louis, 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.