

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044843  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10786**

**FILED NOV 26 1962**

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DATE AMENDED
Rev. 4/59		
1		
2 <b>22</b>		
3		
4 <b>0</b>		
5 <b>2</b>		
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7 <b>1</b>		
8 <b>1</b>		
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12 <b>7.5.3</b>		
13		
<b>75</b>	INSTEAD OF	
USE BLACK INK OR TYPEWRITER RIBBON	DOCUMENT	
ITEM NO.	SHOULD READ	BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</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 HOSPITAL</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3839 MISSOURI AVE</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>N</b> Last <b>SCHUH</b>						4. DATE OF DEATH Month <b>NOV</b> Day <b>8</b> Year <b>1962</b>							
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG 9 1891</b>		9. AGE (last birthday) <b>71</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED TEAMSTER</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <b>ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>			
13a. FATHER'S NAME <b>NICK SCHUH</b>				13b. MOTHER'S MAIDEN NAME <b>MARY HAMBEL</b>				14. NAME OF HUSBAND OR WIFE <b>MARIE SCHUH (DECD)</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.		17. INFORMANT Address <b>HAROLD SCHUH 9904 HACKER PL</b>							
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease;</b> DUE TO (b) <b>Arterio Sclerosis</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 type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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>8:30</b> to <b>A</b> and last saw her/him alive on <b>8-30-A</b> m on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at <b>8:30 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Helen L. Taylor, Coroner</b>						22b. ADDRESS <b>1300 Clark Ave.</b>			22c. DATE SIGNED <b>11-9-62</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>NOV. 10, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. PETER &amp; PAUL CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, MO.</b>		25. DATE RECD. BY LOCAL REG. REGISTRAR'S SIGNATURE <b>NOV 9 1962</b> <b>Road Smith, M.D.</b>					
24. FUNERAL DIRECTOR <b>Thomas Kutis 2906 Gravois</b>													

1911 08 14

Colonel (City)

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 Groves

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.