

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-004674

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 44

FILED JAN 29 1963

VS 300  
Rev. 4/59

1 4000

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS:

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) <b>JEFFERSON BARRACKS, MO.</b>		Length of stay in 1b <b>39 DAYS</b>	c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3616 CLEVELAND AVENUE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>C.</b> Last <b>SCHULZ</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>4</b> Year <b>1963</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>1-20-1890</b>
9. AGE (last birthday) <b>72</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CAB DRIVER (RETIRED)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TAXI CAB</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>LEWIS SCHULZ</b>		13b. MOTHER'S MAIDEN NAME <b>CARRIE YOUNG</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-I</b>		15. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
16. INFORMANT <b>Mrs. Toledo Booth, 4753 Nebraska, St. Louis MO.</b>		17. Address	
18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE INTERSTITIAL PNEUMONIA</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 DAYS</b> DUE TO (b) <b>PULMONARY OBSTRUCTIVE EMPHYSEMA</b> 6 MONTHS DUE TO (c) <b>CANCER OF LEFT LUNG</b>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>DIABETES MELLITUS</b>
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 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.	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, <b>VA</b> , attended the deceased from <b>11-26-62</b> to <b>1-4-63</b> and <b>deceased from 1-4-1963</b> Death occurred at <b>1:10 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>W. Oppler W. OPPLER</b>		22b. ADDRESS <b>M.D. VA HOSP. JEFF. BRKS. MO.</b>	22c. DATE SIGNED <b>1-4-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan 8, 63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks Mo</b>
24. FUNERAL DIRECTOR <b>E.J. Schnur 3125 Lafayette</b>		25. DATE RECD. BY LOCAL REG. <b>1-5-63</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>

STATE OF CALIFORNIA

**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 B. Hallmer*

Licensed Embalmer No. 4014

P. O. Address 3195 Lafayette

**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.