

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-018185

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4041** STATE FILE NUMBER

DO NOT WRITE ON THIS STUD AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

FILED APR 17 1963	
1. PLACE OF DEATH a. COUNTY St. Louis b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b 11 Days c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. 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 checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 5753 Park Lane Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Althea Middle Maude Last Schmidt 4. DATE OF DEATH Month Apr. Day 9 Year 1963	
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 9-11-90 9. AGE (last birthday) 72 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) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (City and state or country) St. Louis, Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.	13a. FATHER'S NAME William A. Ford 13b. MOTHER'S MAIDEN NAME Rose Etta Pfeiffer 14. NAME OF HUSBAND OR WIFE Fred A. Schmidt
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. _____ 17. INFORMANT Fred A. Schmidt, 5753 Park Lane 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) Recurrent carcinoma breast Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Certain sclerotic head disease DUE TO (b) _____ DUE TO (c) 170x 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 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 2-26-63 to 4-9-63 and last saw her alive on 4-9-63 Death occurred at 11:50 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>Lucas J. Ford M.D.</i> (Degree or title) 22b. ADDRESS <i>6000 W. Floumont</i> 22c. DATE SIGNED 4-10-63 (State) _____	23a. BURIAL, CREMATION, REMOVAL (Specify) removal 23b. DATE 4-13-63 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum 23d. LOCATION (City, town, or county) St. Louis County (State) Mo.
24. FUNERAL DIRECTOR Drehmann-Harral, 1905 Union Blvd. ADDRESS _____	25. DATE RECD. BY LOCAL REG. APR 10 1963 26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

Dr. Charles Jost
6000 W. Florissant
Hrs. 12-5 PM Wed.

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

Warren A. Carver

Licensed Embalmer No.

2534

P. O. Address _____

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.