

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022205

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6114**

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 13 1963

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 BY AFFIDAVIT OF

VS 300
 Rev. 4/59
 1
 2 **224**
 3
 4 **1**
 5 **2**
 6
 7 **1**
 8 **2**
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 12 **90-0**
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90

DATE AMENDED
 STATE AMENDED
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay, in 1b 1-mo.	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4725 Nebraska		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2844 Wyoming St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Emma Schulz			4. DATE OF DEATH Month Day Year June 9, 1963
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/22/78
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) Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Illinois
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Frank Kraus	
13b. MOTHER'S MAIDEN NAME Susan Gottschamer		14. NAME OF HUSBAND OR WIFE August Schulz	
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 Mrs. Ottilda Brueggemann		4725 Nebraska Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation			INTERVAL BETWEEN ONSET AND DEATH 1 yr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease			4200
DUE TO (c)			
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 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 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 July 62 to June 9 63 and last saw her alive on June 8 63 Death occurred at 6:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul K. Welford M.D.		22b. ADDRESS 721 Olive St. St. Louis 1 Mo	22c. DATE SIGNED 6-10-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE June 12, 1963	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cem.	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
24. FUNERAL DIRECTOR ADDRESS WACKER-HELDERLE-3634 Gravois Ave.		25. DATE RECD. BY LOCAL REG. JUN 10 1963	26. REGISTRAR'S SIGNATURE Paul Smith M.D.

USE BLACK INK OR TYPEWRITER RIBBON

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 Helit J. Krupin

Licensed Embalmer No. 3497

P. O. Address St. Louis

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.