

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026595

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2027 STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u> | | Length of stay in 1b <u>8 years</u> | c. CITY OR TOWN <u>Webster Groves</u> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>819 Selma</u> | | d. STREET ADDRESS (If outside, give location) <u>819 Selma</u> | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|--|---|--------------------------------|--|
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Schmidt</u> Last <u>Christensen</u> | | | 4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1963</u> | | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-16-70</u> | 9. AGE (last birthday) <u>93</u> | 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) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>self</u> | | 11. BIRTHPLACE (City and state or country) <u>Denmark</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> |
| 13a. FATHER'S NAME <u>Eskil Schmidt</u> | | 13b. MOTHER'S MAIDEN NAME <u>----- Knudsen</u> | | 14. NAME OF HUSBAND OR WIFE <u>Late George Christensen</u> | | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>no</u>) | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Marie C. Suender 819 Selma</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> | | <u>yrs</u> |
| DUE TO (b) <u>Senility</u> | | <u>yrs</u> |
| DUE TO (c) | | |

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| 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 |
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| 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 _____ s.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 attended the deceased from 8-28-40 to 6-23-63 and last saw her alive on 5-20-63
Death occurred at One A m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Edw. J. Allwright MD</u> | 22b. ADDRESS <u>8540 Big Bend</u> | 22c. DATE SIGNED <u>6-24-63</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 23b. DATE <u>6-25-63</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u> | 23d. LOCATION (City, town, or county) <u>Kirkwood, Missouri</u> |
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| 24. FUNERAL DIRECTOR <u>TELBERG-GEDDER</u> COLONIAL CHAPEL WEBSTER GROVES 18. MO. | 25. DATE RECD. BY LOCAL REG. <u>6-24-63</u> | 26. REGISTRAR'S SIGNATURE <u>John B. Murphy MD</u> |
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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 W E Morris

Licensed Embalmer No. 3360

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.