

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-026767
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1958

FILED JUL 5 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch		Length of stay in lb 205 days	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 Robert Koch Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4138 N. Broadway Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last August Frank Schultz			4. DATE OF DEATH Month Day Year 6 15 63
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-28-94
9. AGE (last birthday) 68		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) Retired		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME A. F. Schultz	
13b. MOTHER'S MAIDEN NAME Mary Ott		14. NAME OF HUSBAND OR WIFE Ida West (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs Marjorie Hayes, 4037 Cranberry Lane Robert Koch Hospital, Koch, Mo.			INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) 4201	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Stasis ulcer Lt. leg; chronic lymphedema			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. 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.) 11-21-62	20f. CITY, TOWN, OR LOCATION 6-14-63	COUNTY	STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ 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 <i>[Signature]</i> (Degree or title)		22b. ADDRESS Robert Koch Hospital	22c. DATE SIGNED 6-15-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-19-1963	23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery,	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri.
24. FUNERAL DIRECTOR Math. Hermann & Son Inc. 2161 E. Fair Ave.		25. DATE RECD. BY LOCAL REG. 6/18/63	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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

Allen W. Hart

Licensed Embalmer No. 23739

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.