

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030489

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7847

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT	DATE AMENDED
Rev. 4/59		
1		
2 <u>216</u>		
3		
4 <u>0</u>		
5 <u>0</u>		
6		
7 <u>0</u>		
8 <u>2</u>		
9		
10		
11		
12 <u>2-3</u>		
13		
91	SHOULD READ	BY AFFIDAVIT OF

FILED AUG 15 1963	
1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u> Length of stay in 1b _____ D.O.A. _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____ c. CITY OR TOWN <u>St Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3510 Miami</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>O</u> Last <u>Scholl</u> 4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1963</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/85</u> 9. AGE (last birthday) <u>78</u> IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) <u>St Louis Mo.</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Gustave Scholl</u> 13b. MOTHER'S MAIDEN NAME <u>Louisa Gecks</u> 14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Address <u>Gus Scholl 549 Jackson St St Charles, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u>4221</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ 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. Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
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 _____ 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Paul M. Quinn Deputy</u> 22b. ADDRESS <u>1300 Clark</u> 22c. DATE SIGNED <u>8-1-63</u>	
23a. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>Burial</u> 23b. DATE <u>8/2/63</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u> 23d. LOCATION (City, town, or county) <u>St Louis</u> (State) <u>Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>John L Ziegenhein & Sons 7027 Gravois</u> 25. DATE RECD. BY LOCAL REG. <u>AUG 1 1963</u> 26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>	

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 E. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravois

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.