

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034087

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8633**

FILED AUG 29 1963

VS 300
Rev. 4/59

1

28120
72

3

4 /

5 0

6

7 1

8 2

9

10

11

12 84-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		d. STREET ADDRESS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>							
		St. Louis		9 days		Illinois		Madison		St. Jacob		Box 96											
3. NAME OF DECEASED (Type or print)						First			Middle			Last			4. DATE OF DEATH								
Paula Ann Schuchmann															8-23-63								
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR											
F		W				4-22-63		4		Months		Days		Hours		Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY											
mm none				none				Highland, Illinois				U.S.A.											
13a. FATHER'S NAME						13b. MOTHER'S MAIDEN NAME						14. NAME OF HUSBAND OR WIFE											
Lawrence Edward Schuchmann						Violet Dannmann						None											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)						16. SOCIAL SECURITY NO.						17. INFORMANT Address											
none												E. Worthington 500 S. Kingshighway St. Louis, Mo.											
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>CONGENITAL HEART DISEASE</u>																							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.																							
DUE TO (b) _____																							
DUE TO (c) _____ <u>754.5</u>																							
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 type="checkbox"/> No <input type="checkbox"/> Unknown											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT		SUICIDE		HOMICIDE		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.		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 <u>8-14-63</u> to <u>8-23-63</u> and last saw her/him alive on <u>8-23-63</u> Death occurred at <u>1:15p</u> on the date stated above, and to the best of my knowledge, from the causes stated.																							
22a. SIGNATURE						(Degree or title)						22b. ADDRESS						22c. DATE SIGNED					
<i>Janey Harwell</i>						M.D.						St. Louis Child Hosp						8/24/63					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				(State)							
Removal				8/26/63				Keystone Cemetery				St. Jacob, Illinois											
24. FUNERAL DIRECTOR						ADDRESS						25. DATE RECD. BY LOCAL REG.						26. REGISTRAR'S SIGNATURE					
Aebischer Funeral Home, St. Jacob, Illinois						AUG 26 1963						Roan Smith, M.D.											

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 John J. Saines

Licensed Embalmer No. 4108

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.