

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-038019

STATE FILE NUMBER

Registration District No. 318

318

Primary Registration District No. 1003

1003

Registrar's No. 9267

9267

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
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

FILED SEP 19 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 <u>4 yrs.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bernard Nursing Home</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>4229 Flora Place</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED	
First Middle Last	
<u>CARRIE BELLE SCHOENING</u>	
4. DATE OF DEATH	
Month Day Year <u>September 16, 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>6/22/1880</u>	
9. AGE (last birthday) <u>83</u>	
IF UNDER 1 YEAR IF UNDER 24 HR	
Months Days Hours Min. <u>2 24</u>	
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>At Home</u>	
11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Fred Lauth</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Boehm</u>	
14. NAME OF HUSBAND OR WIFE <u>William L. Schoening</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>	
16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Roy N. Schoening 4229 Flora Pl.</u>	
Address	
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>Cerebral hemorrhage recurrent 1 day</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <u>arteriosclerosis of cerebral arteries 5 years</u>	
DUE TO (c) <u>331A</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Leiomiyomata of uterus</u>	
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 <u>Oct 29, 1962</u> to <u>9/16/63</u> and last saw <u>live</u> on <u>9/5-1963</u>	
Death occurred at <u>6:30</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Joseph Edwards</u>	
22b. ADDRESS <u>M.D. 3720 Washington Blvd.</u>	
22c. DATE SIGNED <u>9/16/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>9/18/63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>St. Louis Co, Missouri</u>	
24. FUNERAL DIRECTOR <u>Ambruster Mortuary 6633 Clayton Road</u>	
25. DATE RECD. BY LOCAL REG. <u>SEP 16 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Road Smith, M.D.</u>	

USE BLACK INK OR TYPEWRITER RIBBON

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*Edwards M.P.
Pinecrest, Pa.
Apr 10, 1918*

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

Fred J. Hammer

Licensed Embalmer No. 4788

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.