

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

163-042424
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3171

FILED OCT 30 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
1 <u>4019</u>								
2 <u>4019</u>								
3								
4 <u>1</u>								
5 <u>1</u>								
6								
7 <u>0</u>								
8 <u>2</u>								
<u>9420.1</u>								
10								
11								
<u>12 10-0</u>								
13								

USE BLACK INK OR TYPEWRITER RIBBON

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>Creve Coeur</u>		c. CITY OR TOWN <u>Creve Coeur</u>	
Length of stay in lb <u>6mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1230 Fee Fee</u>		d. STREET ADDRESS (If outside, give location) <u>1230 Fee Fee</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Middle Last <u>Mildred Louise Schoenberg</u>			4. DATE OF DEATH Month Day Year <u>Oct 16 1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/1907</u>
9. AGE (last birthday) <u>56</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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>Own Home</u>	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>John Shoemate</u>	
13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE <u>Herbert C. Schoenberg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>Herbert Schoenberg</u>		Address <u>1230 Fee Fee</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>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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
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>10/16/63</u> to <u>10/16/63</u> and last saw her alive on <u>10/16/63</u> . Death occurred at <u>7:00</u> <u>7:00A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Clarence L. Clark MD</u>		22b. ADDRESS <u>550 N. Ballus Rd</u>	22c. DATE SIGNED <u>10/17/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/19/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Monicas</u>	23d. LOCATION (City, town, or county) <u>Creve Coeur Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Ortmann F Home 9222 Lackland Overland 14 Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-16-63</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD.</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 Al C Ostmann

Licensed Embalmer No. 3478

P. O. Address Overland, 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.