

FILED APR 7 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

Primary Registration District No.

State File No. 10627
Registrar's No. 3015

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17
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether

In this community.....
years, months or days)

3. (a) PRINT FULL NAME John M. Schaepler

3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Garrie 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Sept. 17 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 6 9 ..hr. ..min

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Moulder

11. Industry or business.....
12. Name John M. Schaepler

13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Hoffman

15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Carrie Schaepler

(b) Address 3704 Ohio

17. (a) Burial (b) Date thereof 3-29-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SS. Peter & Paul Cem.

18. (a) Signature of funeral director Weick Bros. Und. Co.

(b) Address 2201 South Grand Blvd.

19. (a) MAR 29 1948 (b) J. F. Probst
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3704 Ohio 9
24 (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No) 0
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26th
year 1948 hour 12³⁰ minute..... P. M.

21. I hereby certify that I attended the deceased from March 20th
....., 1948, to March 26th, 1948,
that I last saw h.t.m. alive on March 26th, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death..... Post Operative Paralytic Illness 4 days

Due to Operation for Acute Appendicitis 1 wks

Due to..... 1/21

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy Paralytic Illness (Orislet)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....
While at work?..... (Specify type of place)
(e) Means of injury 0

23. Signature C. Arnold's Plm (M. D. or other) MD
Address 2632 S. Kingshighway Date signed 3/27/48

Duration
Physician
Underline the cause of which death should be charged statistically.

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.....
..... Registered Apprentice No.....
working under my personal supervision.

Signed.....

Delis J. Krupin

Licensed Embalmer No.....

3497

P. O. Address.....

2201 S. Grand

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 this body is not embalmed, fact should be so stated above.