

No. 300
-10-47
5-17-39
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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

31602

State File No. _____

FILED OCT 4 1948

Registration District No. 2749

Primary Registration District No. 2002

Registrar's No. 2139

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 7023 Pershing /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community Life _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town University City
(If outside city or town limits, write "RURAL")

(d) Street No. 7023 Pershing Ave
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Milton A. Schaefer

3. (b) If veteran, name war None

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12
year 1948 hour 8 minute 15 p. M.

21. I hereby certify that I attended the deceased from April 5
1948 to Sept 12 1948
that I last saw him alive on Sept 12 1948
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Florence

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased February 3 1903
(Month) (Day) (Year)

Immediate cause of death Broncho-pneumonia terminal of days

Due to Ovarian blastoma metastatic, left parietal lobe.

Due to 560

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

8. AGE: Years 45 Months 7 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation R. R. Clerk

Major findings: April 19, 1948 above findings of brain tumor

Of operations _____

Of autopsy _____

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Albert M. Schaefer

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

14. Maiden name Mary Vogel

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

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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature Joseph Maydon MD (M. D. or other) _____
Address 1520 W. 14th Date signed 9-14-48

16. (a) Informant Mrs. Florence Schaefer

(b) Address 7023 Pershing Ave

17. (a) Burial (b) Date thereof 9-16-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math. Hermann & Son, Inc.

(b) Address 2161 E. Fair Ave

19. (a) 9/10/48 (b) Cecil A. Sharp MD
(Date received local registrar) (Registrar's signature)

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.....

Harold G. Bumble

..... Licensed Embalmer No. *4202*.....

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