

FILED MAY 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17675

#96988

State File No. 4339

318

1003

Registrar's No.

BIRTH NO.

REG. DIST. NO.

PRIMARY REG. DIST. NO.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
b. CITY (If outside corporate limits, write RURAL and give town or town) St. Louis, Mo.			a. STATE Missouri		
c. LENGTH OF STAY (in this place) township			b. COUNTY St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.			c. CITY (If outside corporate limits, write RURAL and give township) University City		
			d. STREET ADDRESS (If rural, give location) 7800 Groby Ave.,		
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)	
PAUL		E.		SCHEIDER	
4. DATE OF DEATH		c. (Last)		5. DATE (Month) (Day) (Year)	
May 14th, 1949					
6. SEX	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male	Widowed	Feb. 14, 1868.		81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retierd		Germany		4	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
William Scheider		Don't Know			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE, OR NAME	
No		None		Mrs. Marguerite Stewing	
				7800 Groby Ave., University City,	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 10 days		
ANTECEDENT CAUSES			DUE TO (b) Hypertension Cerebrovascular dis.		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			DUE TO (c) Generalized arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS			DUE TO (d) Prophosis with cerebral arteriosclerosis		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	
				4821	
22. I hereby certify that I attended the deceased from 4/22/49 , 19___, to 5/14/49 , 19___, that I last saw the deceased alive on 5/14/49 , 19___, and that death occurred at 2:15am , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title)			23b. ADDRESS		23c. DATE SIGNED
W. G. Arney, M. D.			1515 Lafayette Ave.,		5/14/49
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE	24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)
Burial		May 16, 1949	Bethany Cem.,		St. Louis Co., Mo.
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
		J. B. Sauter		Jos. W. Clark, 1125 Hodiamont Ave.,	

MAY 16 1949

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

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.

Signed _____

Signed.....
Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

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