

FILED MAY 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

State File No.

17689

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

Registrar's No.

4250

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 33 yrs		d. STREET ADDRESS (If rural, give location) 6111 Page	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Sanatorium			
3. NAME OF DECEASED (Type or Print) SARAH SCHUYLER a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH May 12 1949 (Month) (Day) (Year)
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Mar. 21, 1916
9. AGE (In years last birthday) 33		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (State or foreign country) St. Louis Mo. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? USAU
13a. FATHER'S NAME Abr. Schuyler		13b. MOTHER'S MAIDEN NAME Rose Bloak	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Abr. Schuyler 6111 Page
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) Cardio-vascular accident		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b)			
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		930	
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? 4 3 2 1			
22. I hereby certify that I attended the deceased from 3-24-46 to 5-12-49, that I last saw the deceased alive on 5-12, 1949, and that death occurred at 6:45 AM from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) U. K. Bensch, M.D.		23b. ADDRESS 5400 Arsenal St	
23c. DATE SIGNED 5/12/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5/13/49	
24c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hag.		24d. LOCATION (City, town, or county) (State) Ladue MO.	
DATE REC'D BY LOCAL REG. MAY 12 1949		REGISTRAR'S SIGNATURE J. B. Pascoe	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Berger Memorial 4715 McPherson	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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.....

.....
working under my personal supervision.

Student Embalmer No.

Signed.....

Lewis L. Ludwig

Signed.....

Student Embalmer

Licensed Embalmer No.

4297

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.