

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28516

State File No. _____

FILED SEP 2 1949
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Registrar's No. 7408

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>no. 4</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Louis City Hospital #1.</u>				d. STREET ADDRESS (If rural, give location) <u>15 4735 Adkins Ave.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>LOUIS</u>		b. (Middle) <u>H.</u>		c. (Last) <u>Scheuerman</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>August 24, 1949</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>December 15, 1887</u>		9. AGE (In years last birthday) <u>61</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>9</u>		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Louis Scheuerman</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Hoesch</u>		14. NAME OF HUSBAND OR WIFE <u>Lilian</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NUMBER (If yes, give war or dates of service) <u>488-10-2169</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Gilbert L. Scheuerman RR2 Valley Park Box 45 C</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Squamous Carcinoma of Lung</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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) <u>474</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>163x</u>			
22. I hereby certify that I attended the deceased from <u>7/14/49</u> to <u>8/24/49</u> , that I last saw the deceased alive on <u>8/24/49</u> , 19 <u>49</u> , and that death occurred at <u>10:30am</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>C. J. Gillham, M.D.</u>		(Degree or title) _____		23b. ADDRESS <u>1515 Lafayette Ave.,</u>		23c. DATE SIGNED <u>8/24/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>August 27, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sun Set Burial Park</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>AUG 26 1949</u>		REGISTRAR'S SIGNATURE <u>J. D. Frazier</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John H. Gebken Sons Und. Co. 2630 Gravois Ave.</u>			

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Robert F. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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.