

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 32157  
8292  
Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Adams	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) Murphysboro	
c. LENGTH OF STAY (in this place) 45 days		d. STREET ADDRESS (If rural, give location) N.R.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital, 17			

3. NAME OF DECEASED (Type or Print) a. (First) LEROY b. (Middle) GENE c. (Last) SCHEMONIA			4. DATE OF DEATH (Month) (Day) (Year) Sept 23 1949		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 8-20-1928		9. AGE (In years last birthday) 21		10. UNDER 1 YEAR 45 IF UNDER 2 Wks. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ira, Ill	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Theodor Schemonia		13b. MOTHER'S MAIDEN NAME Bess Zentler	
14. NAME OF HUSBAND OR WIFE Inogen - Murphysboro Ill		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Inogen		ADDRESS			

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Aplastic anemia DUE TO (c) Thrombocytopenic.  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
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) 72nd Adams	
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? 296X	

22. I hereby certify that I attended the deceased from August 17 1949, to Sept. 23, 1949, that I last saw the deceased alive on Sept 23, 1949, and that death occurred at 4:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE H.R. Bradley		(Degree or title) R.M.D.		23b. ADDRESS Barnes Hospital		23c. DATE SIGNED 9-25-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Remove		24b. DATE 9-23-49		24c. NAME OF CEMETERY OR CREMATORY Murphysboro		24d. LOCATION (City, town, or county) (State) Ill	
DATE REC'D BY LOCAL REG. SEP 27 1949		REGISTRAR'S SIGNATURE Dr. B. Kasater		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Service		ADDRESS 410 P. Marshall	

8292

706T C ACIAL 1

**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 J. Allen Davis Jr.

Licensed Embalmer No. 4053

P. O. Address. ST Louis 10 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.