

FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35544

State File No.

9356

BIRTH NO.		REG. DIST. NO. <b>318</b>	PRIMARY REG. DIST. NO. <b>1003</b>	Registrar's No.
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>MO</b> b. COUNTY <b>JEFFERSON</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>	c. LENGTH OF STAY (in this place) <b>3 DAYS</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>RURAL MERAMEC TOWNSHIP</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>MO. BAPTIST HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>NR NEAR CEDAR HILL - MO.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Roy</b> b. (Middle) <b>ERNEST</b> c. (Last) <b>SCHAFFER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>10 - 28 - 1949</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>OCT 18 - 1910</b>	9. AGE (In years last birthday) <b>39</b> If UNDER 1 YEAR Months Days If UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FILLING STA. OWNER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FILLING STATION</b>	11. BIRTHPLACE (State or foreign country) <b>Cedar Hill MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>FRANK SCHAFFER</b>		13b. MOTHER'S MAIDEN NAME <b>HULDA EGGERS</b>		14. NAME OF HUSBAND OR WIFE <b>EDNA SCHAFFER</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO NONE</b>		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Edna Schaffer Hillboro Mo. RR-2</b>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Rheumatic heart disease with Nutritional embolization</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Acute Rheumatic Fever</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 <b>10 years</b> <b>24 years</b>
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) <b>59</b>		
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? <b>H011</b>		
22. I hereby certify that I attended the deceased from <b>5-3</b> , 1943, to <b>10-28</b> , 1949, that I last saw the deceased alive on <b>10-27</b> , 1949, and that death occurred at <b>7:40 P.M.</b> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <b>Wm. R. Gunn M.D.</b>		23b. ADDRESS <b>1722 S Broadway</b>		23c. DATE SIGNED <b>10/29-49</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>10/31/49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>ST MARTINS. CEM.</b>	24d. LOCATION (City, town, or county) (State) <b>DITTMER MO</b>	
DATE REC'D BY LOCAL REG. <b>OCT 31 1949</b>	REGISTRAR'S SIGNATURE <b>J. B. Fasaler</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John H. Brimmer House Springs Mo</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

9386

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

*Ronald Dyakne*

Licensed Embalmer No. *2917*

P. O. Address *Therion M*

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.