

FILED JAN 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43156**

Registrar's No. **4845**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **3068**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maplewood		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maplewood	
c. LENGTH OF STAY (In this place) 15 YEARS		d. STREET ADDRESS (If rural, give location) 7481 Elm Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 7481 Elm Ave.			

3. NAME OF DECEASED (Type or Print) a. (First) ANNA	b. (Middle) JOHANNA	c. (Last) SEHMANN	4. DATE OF DEATH (Month) (Day) (Year) Dec. 31, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 4-21-1874	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months 8 Days 10	IF UNDER 24 HRS. Hours 10 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME George Quentin	13b. MOTHER'S MAIDEN NAME Marie Detendorf	14. NAME OF HUSBAND OR WIFE late Cornelius Schumann
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Viola Stoecker ADDRESS 7481 Elm Ave. Maplewood 17, Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis		
	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.		4500	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 450.0	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **1945**, 19**45**, to **5-10**, 19**49**, that I last saw the deceased alive on **5-27, 1949**, and that death occurred at **6 P.M.**, from the causes and on the date stated above.

23. SIGNATURE M. E. Shedd (Degree or title)	23b. ADDRESS 961 S. Sprinkler	23c. DATE SIGNED 1/3/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-3-1950	24c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. 1-3-50	REGISTRAR'S SIGNATURE Herbert R. Donike, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE JAY B. SMITH ADDRESS 7450 Manchester Ave. Maplewood 17, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

96
5

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. P. Burgess

Licensed Embalmer No. 4029

P. O. Address Maplewood

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.