

FILED JUN 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17988

State File No. 4902

318

1003

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
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. LENGTH OF STAY (In this place) 5 day		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. FULL NAME OF HOSPITAL OR INSTITUTION St Luke's Hospital	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Luke's Hospital		17 STREET ADDRESS 4102 Botanical		2179 210			
3. NAME OF DECEASED (Type or Print)		a. (First) Emma		b. (Middle) Anna		c. (Last) Bischoff	
4. DATE OF DEATH		Month June		Day 1,		Year 1950	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Jan 24, 1896		9. AGE (In years last birthday) 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Clerk		10b. KIND OF BUSINESS OR INDUSTRY Stl. Wholesale Drug.		11. BIRTHPLACE (State or foreign country) Hamburg, Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Albert Behn		13b. MOTHER'S MAIDEN NAME not known		14. NAME OF HUSBAND OR WIFE Fred C Bischoff			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 497-09-0892		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fred C Bischoff 4102 Botanical			
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) <u>Pulmonary Embolism</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Leiomyosarcoma of Duodenum</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Venous Insufficiency Legs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>6 mo.</u> <u>15 yrs.</u>	
19a. DATE OF OPERATION 5/27/50		19b. MAJOR FINDINGS OF OPERATION <u>Malignancy of Duodenum with Metastases</u>				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, etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>152X</u>			
22. I hereby certify that I attended the deceased from <u>5/24/1948</u> to <u>6/1, 1950</u> , that I last saw the deceased alive on <u>6/1, 1950</u> , and that death occurred at <u>7 p m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W Baumgarten Jr. M.D.</u>				23b. ADDRESS <u>3720 Washington Ave, St. Louis Mo</u>		23c. DATE SIGNED <u>6/3/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) cremation		24b. DATE <u>6/5/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>St Louis County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JUN 3 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Casater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J L Ziegenhein & Sons</u>		ADDRESS <u>7027 Gravois</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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

W. G. Peterson

Signed.....
Student Embalmer

Licensed Embalmer No. *3767*

P. O. Address *St. Louis 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.