

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 25 1950

State File No. 28633
Registrar's No. 7063

318

1003

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 MISSOURI b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS,		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS,		2079			
d. FULL NAME OF HOSPITAL OR INSTITUTION De PAUL Hosp.				7 d. STREET ADDRESS (If rural, give location) 5052 GERALDINE AVE					
3. NAME OF DECEASED (Type or Print) THERESA			a. (First)		b. (Middle) SCHIENE		c. (Last)		
4. DATE OF DEATH (Month) (Day) (Year) August 18-1950		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW		8. DATE OF BIRTH 3/23/1863	
9. AGE (In years last birthday) 87		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) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME UNKNOWN STIENS			13b. MOTHER'S MAIDEN NAME UNKNOWN			14. NAME OF HUSBAND OR WIFE BERNARD SCHIENE			
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 BERNARD SCHIENE				ADDRESS 5052 GERALDINE AVE	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Colon (?)						INTERVAL BETWEEN ONSET AND DEATH ?	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c)							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		21d. HOW DID INJURY OCCUR 153X			
21e. TIME OF INJURY (Month) (Day) (Year) (Hour)		21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22. I hereby certify that I attended the deceased from 8-14, 1950, to 8-18, 1950, that I last saw the deceased alive on 8-18, 1950, and that death occurred at 12:25 p.m., from the causes and on the date stated above.									
23a. SIGNATURE Burch V. Kelly M.D.				23b. ADDRESS 535 N Grand		23c. DATE SIGNED 8-18-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 8/21/50		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		24d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI			
DATE REC'D BY LOCAL REG AUG 21 1950		REGISTRAR'S SIGNATURE J. B. Farster			25. FUNERAL DIRECTOR'S SIGNATURE STROOT - CARROLL 4600 NATURAL BRIDGE				

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

8906

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

Bent Hoffman

Signed.....

Student Embalmer

Licensed Embalmer No. *4366*

P. O. Address *Spring, 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.