

FILED OCT 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31539

#30271

State File No.

BIRTH NO.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 7920

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) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2239
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1			d. STREET ADDRESS (If rural, give location) 918 Barton		
3. NAME OF DECEASED (Type or Print) KATE BISCH			a. (First)	b. (Middle)	c. (Last)
4. DATE OF DEATH Sept. 18th, 1950			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Oct. 5, 1876	9. AGE (In years last birthday) 73
5. SEX Female	6. COLOR OR RACE White	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Peter Schumacher		13b. MOTHER'S MAIDEN NAME Eleanor Unknown		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. ---	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Margaret Schumacher--918 Barton			
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.	<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Psychosis with cerebral arteriosclerosis</i> 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.				INTERVAL BETWEEN ONSET AND 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., to or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR? 206X	
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"/>				
22. I hereby certify that I attended the deceased from 1/13/50, 19__, to 9/18/50, 19__, that I last saw the deceased alive on 9/18/50, 19__, and that death occurred at 7:30am, from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Edwin A. Schmidt M.D.			23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 9/18/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/20/50	24c. NAME OF CEMETERY OR CREMATORY St. Pauls Churchyard	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri		
DATE REC'D BY LOCAL REG. SEP 19 1950	REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Helders 3634 Gravois		

WRITE PLAINLY—USING UNFAADING 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 _____

Frank J. [Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. 2645

P. O. Address [Signature]

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.