

39001

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 17 1950

State File No. 9441

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 Missouri b. COUNTY		
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 68 Years	c. CITY (If outside corporate limits, write RURAL and give township) 8 OR TOWN St. Louis		2089
d. FULL NAME OF HOSPITAL OR INSTITUTION 1719 Grape Ave.			d. STREET ADDRESS (If rural, give location) 1719 Grape Ave.		

3. NAME OF DECEASED (Type or Print) a. (First) Emma b. (Middle) L. c. (Last) Schaperkotter			4. DATE OF DEATH (Month) (Day) (Year) Nov. 4 1950		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH March 19 1882		9. AGE (In years last birthday) 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		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 William C.F. Schaperkotter		13b. MOTHER'S MAIDEN NAME Wilhelmena Hilgeman		14. NAME OF HUSBAND OR WIFE Never Married	
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 Miss Bertha Schaperkotter, 1719 Grape Ave.	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Nephritis c Edema ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes Mellitus DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 yrs 8 yrs
		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 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. 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? <i>Heel</i>	
22. I hereby certify that I attended the deceased from <i>MAR 1 1950</i> to <i>Nov. 4 1950</i> , that I last saw the deceased alive on <i>Nov 7, 1950</i> , and that death occurred at <i>1:45 P.m.</i> , from the causes and on the date stated above.					

23a. SIGNATURE <i>J. B. Medler M.D.</i> (Degree or title)		23b. ADDRESS <i>4114 W. Howsart</i>		23c. DATE SIGNED <i>11/6/50</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov. 7, 1950	24c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	

DATE REC'D BY LOCAL REG. NOV 7 1950		REGISTRAR'S SIGNATURE <i>J. B. Leater</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BEIDERWIEDEN F.H. INC. 1936 St. Louis Ave.	
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(Licensed Embalmer's Statement on Reverse Side)

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

S. No. 300
V. 10.48

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 _____

Max L. Wapfel

Signed _____
Student Embalmer

Licensed Embalmer No. 4170

P. O. Address 1936 St. Louis Ave

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.