

FILED JAN 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2970

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 228

1. PLACE OF DEATH a. COUNTY		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 St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3840 Bates		d. STREET ADDRESS (If rural, give location) 3840 Bates	

3. NAME OF DECEASED (Type or Print) a. (First) Josephine b. (Middle) F. c. (Last) Schollmeyer			4. DATE OF DEATH (Month) (Day) (Year) January 7 1951		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED? (Specify) Married	8. DATE OF BIRTH October 11 1882	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months 2	IF UNDER 48 HRS. Hours 26	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Henry Foegeding	13b. MOTHER'S MAIDEN NAME Christina Huber	14. NAME OF HUSBAND OR WIFE William A. Schollmeyer
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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. None	17. INFORMANT'S SIGNATURE OR NAME Mrs Lillian E. Mosbacher	ADDRESS 5340 Emerson
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 20 min years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive C-V Disease</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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? H - X
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22. I hereby certify that I attended the deceased from June 2, 1949, to Jan 7, 1951, that I last saw the deceased alive on Jan 3, 1951, and that death occurred at 9:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE Wm. C. Macdonald M.D.	(Degree or title)	23b. ADDRESS 2539 N. Grand	23c. DATE SIGNED 1-9-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE January 10 1951	24c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co Mo
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DATE REC'D BY LOCAL REG. JAN 10 1951	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Calvin F Feutz	ADDRESS 4828 Nat Bridge Blvd
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(Licensed Embalmer's Statement on Reverse Side)

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.....

Ralph C. Sanders

Signed.....
Student Embalmer

Licensed Embalmer No. 4275

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.