

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**31820**

State File No. ....

No. 300  
10.48

**FILED SEP 22 1951**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1002** Registrar's No. **7950**

|                                                                                                                                                                                                                                      |                         |                                                                                                 |                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------|
| <b>1. PLACE OF DEATH</b>                                                                                                                                                                                                             |                         | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).   |                                         |
| a. COUNTY <b>ST LOUIS</b>                                                                                                                                                                                                            |                         | a. STATE <b>MO</b> b. COUNTY <b>ST LOUIS</b>                                                    |                                         |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST LOUIS</b>                                                                                                                                         |                         | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST LOUIS</b>    |                                         |
| c. LENGTH OF STAY (in this place) <b>2 YRS</b>                                                                                                                                                                                       |                         | d. STREET ADDRESS (If rural, give location) <b>5226 WELLS AVE</b>                               |                                         |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5226 WELLS AVE</b>                                                                                                                                                                        |                         | e. STREET ADDRESS <b>5226 WELLS AVE</b>                                                         |                                         |
| <b>3. NAME OF DECEASED</b>                                                                                                                                                                                                           |                         |                                                                                                 | <b>4. DATE OF DEATH</b>                 |
| a. (First) <b>BERTHA</b> b. (Middle) <b>ELIZABETH</b> c. (Last) <b>SCHAFFER</b>                                                                                                                                                      |                         |                                                                                                 | (Month) (Day) (Year) <b>SEPT 6 1951</b> |
| <b>5. SEX</b>                                                                                                                                                                                                                        | <b>6. COLOR OR RACE</b> | <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b>                                   | <b>8. DATE OF BIRTH</b>                 |
| <b>FEMALE</b>                                                                                                                                                                                                                        | <b>WHITE</b>            | <b>WIDOWED 4</b>                                                                                | <b>MARCH 21-1877</b>                    |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)                                                                                                                                   |                         | <b>11. BIRTHPLACE</b> (State or foreign country)                                                |                                         |
| <b>HOUSEWIFE</b>                                                                                                                                                                                                                     |                         | <b>TROY MO</b>                                                                                  |                                         |
| <b>10b. KIND OF BUSINESS OR INDUSTRY</b>                                                                                                                                                                                             |                         | <b>12. CITIZEN OF WHAT COUNTRY?</b>                                                             |                                         |
| <b>OWN HOME</b>                                                                                                                                                                                                                      |                         | <b>USA</b>                                                                                      |                                         |
| <b>13a. FATHER'S NAME</b>                                                                                                                                                                                                            |                         | <b>14. NAME OF HUSBAND OR WIFE</b>                                                              |                                         |
| <b>THOMAS B. BROWN</b>                                                                                                                                                                                                               |                         | <b>FRANK. SCHAFFER</b>                                                                          |                                         |
| <b>13b. MOTHER'S MAIDEN NAME</b>                                                                                                                                                                                                     |                         | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b>                                              |                                         |
| <b>SUSAN EAST</b>                                                                                                                                                                                                                    |                         | <b>NO</b>                                                                                       |                                         |
| <b>16. SOCIAL SECURITY NO.</b>                                                                                                                                                                                                       |                         | <b>17. INFORMANT'S SIGNATURE OR NAME</b>                                                        |                                         |
| <b>NONE</b>                                                                                                                                                                                                                          |                         | <b>Joseph L. Russell</b>                                                                        |                                         |
|                                                                                                                                                                                                                                      |                         | <b>5226 Wells</b>                                                                               |                                         |
| <b>18. CAUSE OF DEATH</b>                                                                                                                                                                                                            |                         |                                                                                                 | <b>INTERVAL BETWEEN ONSET AND DEATH</b> |
| Enter only one cause per line for (a), (b), and (c)                                                                                                                                                                                  |                         |                                                                                                 | <b>1 day.</b>                           |
| <b>1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Pulmonary infarct</b>                                                                                                                                               |                         |                                                                                                 |                                         |
| <b>ANTECEDENT CAUSES</b>                                                                                                                                                                                                             |                         |                                                                                                 |                                         |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                                                                                         |                         |                                                                                                 |                                         |
| Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.                                                                                                                                     |                         |                                                                                                 | <b>1 1/2 years</b>                      |
| DUE TO (b) <b>Carcinoma of the right bronchus</b>                                                                                                                                                                                    |                         |                                                                                                 |                                         |
| DUE TO (c)                                                                                                                                                                                                                           |                         |                                                                                                 |                                         |
| <b>II. OTHER SIGNIFICANT CONDITIONS</b>                                                                                                                                                                                              |                         |                                                                                                 |                                         |
| Conditions contributing to the death but not related to the disease or condition causing death.                                                                                                                                      |                         |                                                                                                 |                                         |
| <b>19a. DATE OF OPERATION</b>                                                                                                                                                                                                        |                         | <b>20. AUTOPSY?</b>                                                                             |                                         |
| <b>None</b>                                                                                                                                                                                                                          |                         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |                                         |
| <b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)                                                                                                                                                                                      |                         | <b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) |                                         |
|                                                                                                                                                                                                                                      |                         |                                                                                                 |                                         |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)                                                                                                                                                                               |                         | <b>21f. HOW DID INJURY OCCUR?</b>                                                               |                                         |
| <b>No injury</b>                                                                                                                                                                                                                     |                         | <b>162 X</b>                                                                                    |                                         |
| <b>21e. INJURY OCCURRED</b>                                                                                                                                                                                                          |                         |                                                                                                 |                                         |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                    |                         |                                                                                                 |                                         |
| <b>22. I hereby certify that I attended the deceased from Mar. 29, 1950, to Sep. 6, 1951 that I last saw the deceased alive on Sep. 6, 1951, and that death occurred at 10:10p.m., from the causes and on the date stated above.</b> |                         |                                                                                                 |                                         |
| <b>23a. SIGNATURE</b> (Degree or title)                                                                                                                                                                                              |                         | <b>23b. ADDRESS</b>                                                                             |                                         |
| <b>Henry Rosenberg M.D.</b>                                                                                                                                                                                                          |                         | <b>1467 N. Union Blvd.</b>                                                                      |                                         |
|                                                                                                                                                                                                                                      |                         | <b>23c. DATE SIGNED</b>                                                                         |                                         |
|                                                                                                                                                                                                                                      |                         | <b>Sep. 7, 1951</b>                                                                             |                                         |
| <b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b>                                                                                                                                                                                     |                         | <b>24c. NAME OF CEMETERY OR CREMATORY</b>                                                       |                                         |
| <b>ST LOUIS</b>                                                                                                                                                                                                                      |                         | <b>St Louis</b>                                                                                 |                                         |
| <b>24b. DATE</b>                                                                                                                                                                                                                     |                         | <b>24d. LOCATION</b> (City, town, or county) (State)                                            |                                         |
| <b>SEPT 7. 1951</b>                                                                                                                                                                                                                  |                         | <b>St Louis MO</b>                                                                              |                                         |
| <b>DATE REC'D BY LOCAL REG.</b>                                                                                                                                                                                                      |                         | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b>                                                         |                                         |
| <b>SEP 7 1951</b>                                                                                                                                                                                                                    |                         | <b>Robins Funeral Home</b>                                                                      |                                         |
| <b>REGISTRAR'S SIGNATURE</b>                                                                                                                                                                                                         |                         | <b>ADDRESS</b>                                                                                  |                                         |
| <b>Earl Smith M.O.</b>                                                                                                                                                                                                               |                         | <b>St Louis MO</b>                                                                              |                                         |

(Licensed Embalmer's Statement on Reverse Side)

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

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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 Me

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Frank Prokoff

Licensed Embalmer No. 4356

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.