

FILED DEC 15 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39693

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 10851

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|--|------------------------------|---|---|---|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 10851 | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY _____ | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis Mo</u> | | c. LENGTH OF STAY (in this place) _____ | | c. CITY (If outside corporate limits, write RURAL and give township) <u>10 TOWN St. Louis</u> | | <u>2169</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1424 Salisbury</u> | | | | d. STREET ADDRESS (If rural, give location) <u>4484 Penrose</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Sophie</u> b. (Middle) _____ c. (Last) <u>Schroeder</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>12 6 1951</u> | | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>Jan-27-1890</u> | | 9. AGE (In years last birthday) <u>71</u> If under 1 year: Months _____ Days _____ If under 1 hr: Hours _____ Mins. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S</u> | |
| 13a. FATHER'S NAME <u>Anthony Kemperolte</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Freise</u> | | 14. NAME OF HUSBAND OR WIFE <u>Anthony Schroeder - Deceased</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Veronica Jones - 1424 Salisbury</u> | | | |
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Primary Carcinoma of sigmoid</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> | | | | | |
| 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. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>153X</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>5/14/51</u> , 19 <u>51</u> , to <u>12/6/51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>12/6/51</u> , 19 <u>51</u> , and that death occurred at <u>2:20</u> m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Dr. T. D. Bluelock</u> | | | | 23b. ADDRESS <u>8000 1415 Salisbury St. Louis</u> | | 23c. DATE SIGNED <u>12/7/51</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>Dec 10, 1951</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u> | | 24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u> | |
| DATE REC'D BY LOCAL REG. <u>DEC 7 1951</u> | | REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ans Koch + Son - 3516 S. 14th</u> | | | |

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Ronald O. Yabuke

Licensed Embalmer No. *3917*

P. O. Address *St. Louis*

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.