

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10543

State File No.

FILED APR 12 1952

2878

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

1. PLACE OF DEATH a. COUNTY ST. LOUIS, MO.		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 _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 4715 San Francisco	

3. NAME OF DECEASED (Type or Print), a. (First) MARY	b. (Middle) SCHAECHER	c. (Last) _____	4. DATE OF DEATH (Month) (Day) (Year) 3 25 52
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1-27-1900	9. AGE (In years last birthday) 52	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 1 Mth. Hour _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Henry Dickman	13b. MOTHER'S MAIDEN NAME Louise Huebler	14. NAME OF HUSBAND OR WIFE August
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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 August Schaecher	ADDRESS 4715 San Francisco
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) DISSEMINATED CARCINOMA (PRIMARY UNKNOWN)		INTERVAL BETWEEN ONSET AND DEATH
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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 1998
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22. I hereby certify that I attended the deceased from **3/16**, 19**52**, to **3/25**, 19**52**, that I last saw the deceased alive on **3/25**, 19**52**, and that death occurred at **6:15am.**, from the causes and on the date stated above.

22a. SIGNATURE FR Bradley (Degree or title) _____	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 3-25-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 3-28-1952	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) St Louis County Mo
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DATE REC'D BY LOCAL REG. MAR 27 1952	REGISTRAR'S SIGNATURE K. Carl Smith MD	2. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary	ADDRESS 4104 Manchester
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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 Beryl J. Johnson

Licensed Embalmer No. 4366

P. O. Address Waco, TX

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.