

MAR 29 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10546

2460

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give town or township) ST. LOUIS, c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION 5441 DONOVAN AVE				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS, d. STREET ADDRESS (If rural, give location) 5441 DONOVAN AVE			
3. NAME OF DECEASED (Type or Print) a. (First) ELIZABETH b. (Middle) _____ c. (Last) SCHAFFNER		4. DATE OF DEATH (Month) (Day) (Year) MARCH 12, 1952		5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW		8. DATE OF BIRTH 8/1/1865		9. AGE (In years last birthday) 86		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		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 CASPER UNLAND		13b. MOTHER'S MAIDEN NAME CLARA NIEMANN		14. NAME OF HUSBAND OR WIFE FREDRICK SCHAFFNER			
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 ADDRESS MRS. ADA LAMPMAN 5441 DOVOVAN 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Arteriosclerosis Terminal ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Paralysis Agitans DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH Several years	
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) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 350X				22. I hereby certify that I attended the deceased from 1848 to March 1, 1952 , that I last saw the deceased alive on 19 and that death occurred at 7:45 Pm. , from the causes and on the date stated above.	
23a. SIGNATURE Robert W. ...		23b. ADDRESS 467 E. Belmont		23c. DATE SIGNED 3/14/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE 3/15/52		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		24d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI	
DATE REC'D BY LOCAL REG. MAR 14 1952		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE AVE			

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

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11/5/2

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.....

Albert Mayfield

Signed.....

Student Embalmer

Licensed Embalmer No.....

13077

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.