

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

36820

State File No.

9862

FILED NOV 13 1952

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u> <u>2209</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1</u>		d. STREET ADDRESS (If rural, give location) <u>2628 St. Louis Ave.</u>	

3. NAME OF DECEASED (Type or Print) <u>KATE</u>	a. (First)	b. (Middle)	c. (Last) <u>SCHOLL</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 25, 1952</u>
-------------------------------------------------	------------	-------------	-------------------------	------------------------------------------------------------

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 15, 1865</u>	9. AGE (In years last birthday) <u>87</u>	10. MONTHS <u>1</u>	11. DAYS <u>7</u>	12. HOURS <u>1</u>	13. MIN. <u>7</u>
----------------------	-------------------------------	-----------------------------------------------------------------------	----------------------------------------	-------------------------------------------	---------------------	-------------------	--------------------	-------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>England</u>	12. CITIZEN OF WHAT COUNTRY? <u>4</u>
--------------------------------------------------------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------------	---------------------------------------

13a. FATHER'S NAME <u>John Sheeley</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Late Fred Scholl</u>
----------------------------------------	------------------------------------------	-----------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Benjamin F. Scholl</u>	ADDRESS <u>6153 Lillian Av</u>
-------------------------------------------------------------------	-------------------------	-------------------------------------------------------------	--------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Failure</u>	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (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.	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Malnutrition</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>1999</u>
-------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------------------

22. I hereby certify that I attended the deceased from 10-22-52, 19 to 10-25-52, 19, that I last saw the deceased alive on 10-25-52, 19, and that death occurred at 7:45 Am., from the causes and on the date stated above.

23a. SIGNATURE <u>J. R. Edwards Jr. M.D.</u> (Degree or title)	23b. ADDRESS <u>1515 Lafayette Avenue</u>	23c. DATE SIGNED <u>10-25-52</u>
----------------------------------------------------------------	-------------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct. 29, 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
---------------------------------------------------------	--------------------------------	--------------------------------------------------------------	----------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <u>OCT 27 1952</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Leidner Und. Co.</u>	ADDRESS <u>2223 St. Louis Av.</u>
---------------------------------------------	-------------------------------------------------	----------------------------------------------------------	-----------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

Carcinoma atasis - Primary site unknown.

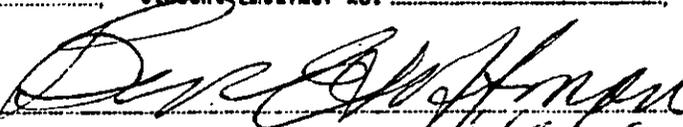
STATEMENT BY LICENSED EMBALMER

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. _____

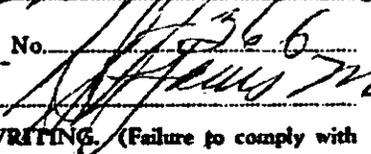
working under my personal supervision.

Signed _____



Student
Student Embalmer

Licensed Embalmer No. _____



P. O. Address _____

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.