

FILED AUG 12 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26863

| | | | | | | | |
|--|---|--|---|---|---|---|---|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 6184 | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Mo b. COUNTY St. Louis | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis | | | c. LENGTH OF STAY (In this country) 10 days | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Frontenac | | | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St Anthony Hospital | | | | d. STREET ADDRESS (If rural, give location) 7 West Geyer Lane 4410 | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Henry | | | b. (Middle) _____ | | c. (Last) Schaumburg | | 4. DATE OF DEATH (Month) (Day) (Year) June 20, 1953 |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed | | 8. DATE OF BIRTH Feb 21, 1872 | | 9. AGE (In years last birthday) 81 | IF UNDER 1 YEAR Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) Lawrence, Kansas | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME Henry Schaumburg | | 13b. MOTHER'S MAIDEN NAME Teresa Mueller | | 14. NAME OF HUSBAND OR WIFE Annie Schaumburg | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ruth Fries 7 West Geyer Lane | | | |
| 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) Encephalitis, Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Encephalo Malacia DUE TO (c) Arterio Sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 week 3 yrs |
| 19. DATE OF OPERATION 6-19-53 | | 19b. MAJOR FINDINGS OF OPERATION Cataract June 13, 1953 | | | | | 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? 332X | | | |
| 22. I hereby certify that I attended the deceased from Feb 21, 1872 to June 20, 1953 that I last saw the deceased alive on June 17, 1953 , and that death occurred at 4:45 p. m. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE Carl Smith (Degree or title) MD | | | 23b. ADDRESS 607 No. Grand | | 23c. DATE SIGNED 6-20-53 | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 6/22/53 | 24c. NAME OF CEMETERY OR CREMATORY N St Marcus Cemetery | | 24d. LOCATION (City, town, or county) (State) St Louis Mo. | | |
| DATE REC'D BY LOCAL REG. JUN 22 1953 | | REGISTRAR'S SIGNATURE Carl Smith MD | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J L Ziegenhein & Sons 7027 Gravois | | | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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 Nevelle D. Frohwitter

Licensed Embalmer No. 3696

P. O. Address 7027 Gravois

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.