

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34015

FILED OCT 15 1953

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8702**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 18 days		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) WILLIAM		a. (First) WILLIAM		b. (Middle) M.	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) packer United Drug		10b. KIND OF BUSINESS OR INDUSTRY Drug supplies		8. DATE OF BIRTH Jan. 13 1888	
13a. FATHER'S NAME John Michael Schrempf		13b. MOTHER'S MAIDEN NAME Meerpohl		14. NAME OF HUSBAND OR WIFE Nora Schrempf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 488 09 8947		17. INFORMANT'S SIGNATURE OR NAME Nora Schrempf ADDRESS 5443 Ruskin	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES Myocardial Infarction Atrial Fibrillation DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			
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) 4201	
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?	
22. I hereby certify that I attended the deceased from Aug 17, 1953 , to Sept 4, 1953 , that I last saw the deceased alive on Sept 4, 1953 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above.					
23a. SIGNATURE John G. McEnany MD (Degree or title)		23b. ADDRESS 5014 Thekla Shores		23c. DATE SIGNED 9/5/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE sept. 8, 1953		24c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon	
DATE REC'D BY LOCAL REG. SEP-8 1953		REGISTRAR'S SIGNATURE Charles Smith MD		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
25. FUNERAL DIRECTOR'S SIGNATURE Buchholz Koeller		ADDRESS 5967 W. Florissant			

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.....
Signature of Student Embalmer

Signed *Walter F. Bushby*.....
Licensed Embalmer No. *4557*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.