

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37560

State File No. \_\_\_\_\_

FILED NOV 6 - 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9504**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>LEMAY 4850</b>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <b>RT. 9, BOX 586 D</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>MAMIE</b> b. (Middle) <b>****</b> c. (Last) <b>SCHEPP</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>OCT. 2, 1953</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	
8. DATE OF BIRTH <b>NOV. 19, 1896</b>		9. AGE (In years last birthday) <b>56</b>		10. AGE (In years last birthday) IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>ST. LOUIS, MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					

13a. FATHER'S NAME <b>HERMAN SCHERPEN</b>		13b. MOTHER'S MAIDEN NAME <b>MARIE HOLLIDAY</b>		14. NAME OF HUSBAND OR WIFE <b>FERDINAND SR.</b>	
--	--	--	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>DOLORES JOHNSON</b>	
				ADDRESS <b>RT. 9, BOX 586D, LEMAY, MO.</b>	

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				INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>Saddle thrombus of rt. iliac artery with gangrene of entire right leg, diabetes mellitus</b>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>DUPLICATE</b>				DUCE TO (b) _____	
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>General arteriosclerosis</b>		DUCE TO (c) _____				10 yrs.	

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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>260X</b>			

22. I hereby certify that I attended the deceased from **3-18, 1944**, to **10-2, 1953**, that I last saw the deceased alive on **10-2, 1953**, and that death occurred at **7:40 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Frank A. Bailey MD</b>		(Degree or title)		23b. ADDRESS <b>3108 So. Grand Blvd.</b>		23c. DATE SIGNED <b>10-3-53</b>	
---	--	-------------------	--	---	--	------------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>OCT. 5, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>PARK LAWN CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>1800 LEMAY FERRY ROAD</b>	
---	--	----------------------------------	--	---	--	---	--

DATE REC'D BY LOCAL REG. <b>OCT 5 1953</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>H. HOFFMEISTER U. &amp; L. CO.</b>		ADDRESS <b>7817 SO. BROADWAY ST. LOUIS, MO.</b>	
---	--	---	--	---	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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 *Harry J. Schumann*

Licensed Embalmer No. *2679*

P. O. Address *2814 J-Broadway*

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.