

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

State File No. **6758**
Registrar's No. **1214**

FILED MAR 4 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri, b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis,		c. LENGTH OF STAY (in this place) OR TOWN St. Louis,	
d. FULL NAME OF HOSPITAL OR INSTITUTION Pronounced dead at City Hosp.		d. STREET ADDRESS (If rural, give location) 2500 Ohio Ave.,	

3. NAME OF DECEASED (Type or Print) Frank H. Schaefer			4. DATE OF DEATH February 6, 1954 (Month) (Day) (Year)		
5. SEX Male.	6. COLOR OR RACE White.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single.	8. DATE OF BIRTH March 27 1881	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Front Rank Furnace Co		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri,	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Frank Schaefer	13b. MOTHER'S MAIDEN NAME Mary A. Cahill	14. NAME OF HUSBAND OR WIFE
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.	17. INFORMANT'S SIGNATURE OR NAME Willard H. Schaefer, 3345 Liberty St.,

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		19. INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **1002 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Catrina L. Taylor Coroner (Degree or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 2.8.54.
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal,	24b. DATE 2/9/54	24c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery,	24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.
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DATE REC'D BY LOCAL REG. FEB 8 1954	REGISTRAR'S SIGNATURE J. Charles Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Gebken-Benz Mortuary,	ADDRESS 2842 Meramec St., St. Louis, 18, Mo.
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mfb (Licensed Embalmer's Statement on Reverse Side)

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 _____ me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____
2842 Meramec St.,
St. Louis, 18, Mo.

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.