

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21196

State File No. ....

FILED JUN 24 1954

318

1003

Registrar's No. .... 5018

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.		b. COUNTY 2019	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (In this place) 1		e. STREET ADDRESS 7143 Alabama		(If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL					

3. NAME OF DECEASED (Type or Print) a. (First) NELLIE b. (Middle) SCHAEFER c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) JUNE 4, 1954		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 9 1869	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (If we kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Michigan	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME DeWit Youngs	13b. MOTHER'S MAIDEN NAME Jurica Umpstead	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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mable Burkemper	ADDRESS 7143 Alabama
--	-------------------------	--	-------------------------

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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Generalized Atherosclerosis</i>		
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 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) 4500
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	---	----------------------------

22. I hereby certify that I attended the deceased from 5-22-54, 19, to 6-4-54, 19, that I last saw the deceased alive on 6-4-54, 19, and that death occurred at 3:30A m., from the causes and on the date stated above:

23a. SIGNATURE (Degree or title) Edward P. Flynn M.D.	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 6-4-54
--	---------------------------------------	----------------------------

24a. BURIAL: CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-7-1954	24c. NAME OF CEMETERY OR CREMATORY Park Lawn	24d. LOCATION (City, town, or county) (State) Lemay Mo.
--	-----------------------	---	--

DATE REC'D BY LOCAL REG. JUN 7 1954	REGISTRAR'S SIGNATURE Charles Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Jos. P. Fendler Jr.	ADDRESS 7128 Michigan
--	---	---	--------------------------

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 *Clarence Kochou*.....

Licensed Embalmer No. *309*

P. O. Address *7128*.....

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.