

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25185

6264

BIRTH NO. 48645-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE Mo. b. COUNTY				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2109		
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmen Desloge Hospital				d. STREET ADDRESS (If rural, give location) 15 4637 Oregon				
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) — c. (Last) Schaefer			4. DATE OF DEATH (Month) (Day) (Year) 7 11 54					
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 7-10-54		9. AGE (In years last birthday) 6	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo.		12. CITIZEN OF WHAT COUNTRY? 6		
13a. FATHER'S NAME Andrew Schaefer			13b. MOTHER'S MAIDEN NAME Mary Rosary Mitra		14. NAME OF HUSBAND OR WIFE None			
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 Mary Rosary Mitra Schaefer				
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) Premature Birth ANTECEDENT CAUSES *Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature Separation of Placenta DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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 7615				
22. I hereby certify that I attended the deceased from 7-10-1954, to 7-11-1954, that I last saw the deceased alive on 7-11-1954, and that death occurred at 4:30 a. m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) Sharon Smith MD				23b. ADDRESS 607 N Grand		23c. DATE SIGNED 7-12-54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/13/54	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St Louis Missouri			
DATE REC'D BY LOCAL REG. JUL 12 1954		REGISTRAR'S SIGNATURE Charles Smith MS		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home 1926 Allen Av				

(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 *Not Embalmed* by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Reinhold K. Lehman*

Licensed Embalmer No. *3395*

P. O. Address *St. Louis 47*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.