

FILED SEP 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32157

BIRTH NO. 65254-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8114

I. 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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS (If rural, give location) 5321 Belleview 2099/10	
3. NAME OF DECEASED (Type or Print) a. (First) Dale b. (Middle) Thomas c. (Last) Schaeffler		4. DATE (Month) (Day) (Year) OF DEATH September 2, 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 9-1-1954
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min. 21 23
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S.	
13a. FATHER'S NAME Thomas Charles Schaeffler		13b. MOTHER'S MAIDEN NAME Rose Marie Krone	14. NAME OF HUSBAND OR WIFE -----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Schaeffler 5321 Belleview, St. Louis
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemolytic anemia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Intracranial hemorrhage DUE TO (c) Intrapulmonary hem. 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? 7600	
22. I hereby certify that I attended the deceased from 9/1, 1954, to 9/2, 1954, that I last saw the deceased alive on 9/2, 1954, and that death occurred at 3 A. m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Charles G. Molten, MD		23b. ADDRESS 3121 N. Grand Blvd.	23c. DATE SIGNED 9-3-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-3-54	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery,	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
DATE REC'D BY LOCAL REG. SEP 3 1954	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Stock Mortuaries, 2117 E. Grand Bl.	

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Frank A. Moore*

Licensed Embalmer No. *3041*

P. O. Address *2117 E. Main*

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

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