

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **32159**

FILED SEP 16 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7872**

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| b. CITY (If outside corporate limits, write RURAL and give OR township) | | a. STATE | |
| St. Louis | | Missouri | |
| c. LENGTH OF STAY (In this place) | | b. COUNTY | |
| | | St. Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | c. CITY OR TOWN | |
| Missouri-Baptist Hospital | | St. Louis | |
| | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| | | • STREET ADDRESS (If rural, give location) | |
| | | 3632 Wilmington Ave | |

| | | | | | |
|---------------------|-------------|--------------|------------------|-------|--------|
| 3. NAME OF DECEASED | | | 4. DATE OF DEATH | | |
| a. (First) | b. (Middle) | c. (Last) | (Month) | (Day) | (Year) |
| Louise | | Schaubenberg | 8-23 | 1954 | |

| | | | | | | | |
|--------|------------------|--|------------------|---------------------------------|--|--|------------------------------|
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (City and State or Foreign Country) | 12. CITIZEN OF WHAT COUNTRY? |
| Female | White | Married | 5-7-1871 | 83 | Housewife | Missouri | U.S.A. |

| | | |
|--------------------|---------------------------|-----------------------------|
| 13a. FATHER'S NAME | 13b. MOTHER'S MAIDEN NAME | 14. NAME OF HUSBAND OR WIFE |
| Gottlieb Wittler | Amelia Weillner | Edwin G. Schaubenberg |

| | | | |
|--|-------------------------|-----------------------------------|---------------|
| 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 | ADDRESS |
| No | None | Oliver Schaubenberg | 4420 Ohio Ave |

| | | | |
|---|---|---|----------------------------------|
| 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. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) | | INTERVAL BETWEEN ONSET AND DEATH |
| | Pulmonary embolus | | |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |
| ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | DUE TO (b) | |
| | | carcinoma right colon | |
| | | DUE TO (c) | |
| | | arteriosclerotic heart disease Diabetes mellitus | |

| | | |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
| | carcinoma right colon | 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) (m.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
| | | 153 x |

22. I hereby certify that I attended the deceased from 2 August 54 to 23 August 54 that I last saw the deceased alive on 23 Aug 1954 and that death occurred at 11 A.m., from the causes and on the date stated above.

| | | |
|----------------------------------|-----------------|------------------|
| 23a. SIGNATURE (Degree or title) | 23b. ADDRESS | 23c. DATE SIGNED |
| Harry A Wittler M.D. | 9929 Manchester | 25 Aug 54 |

| | | | |
|---|-----------|------------------------------------|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
| Burial | 8-26-1954 | St. Matthews Cemetery | 4260 Bates St Mo |

| | | |
|---|----------------------------------|-----------------------------------|
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
| AUG 26 1954 | J. Earl Smith, M.D. | Ziegenfuss Bros. 6409 Gravois Ave |

(Licensed Embalmer's Statement of Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
WC 1-5484

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 *Paul A. Waelter*.....

Licensed Embalmer No. *478*.....

P. O. Address *Louis*.....

**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.**