

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 39204  
9717

BIRTH NO. \_\_\_\_\_ 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 <u>Missouri</u> b. COUNTY					
b. CITY OR TOWN <u>ST. LOUIS MO</u>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>ST. LOUIS</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>2637 IOWA</u>		e. STREET ADDRESS (If rural, give location) <u>17 3966 - CLEVELAND 2176</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARGARET</u> b. (Middle) <u>SCHERZINGER</u> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 26 1954</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)			
		<u>WIDOW</u>		8. DATE OF BIRTH <u>MAR. 24 1879</u>			
9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIDOW</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>AUSTRIA</u>			
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>JOHN FEILER</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>JOS. SCHERZINGER DEC'D</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>ERMA STEFFEL</u> ADDRESS <u>2637 IOWA</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of gall bladder</u> 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.				INTERVAL BETWEEN ONSET AND DEATH <u>6 mos 27</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Ca of gall bladder, several stones, melastoma to liver</u>				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, store, 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? <u>155x</u>			
22. I hereby certify that I attended the deceased from <u>12-21</u> , 19 <u>53</u> , to <u>10-25</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>10-24</u> , 19 <u>54</u> , and that death occurred at <u>1:30 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Wayne J. Smith MD</u> (Degree or title)				23b. ADDRESS <u>2729 N. Grand</u>			
23c. DATE SIGNED <u>10-26-54</u>							
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>OCT 28 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>S.S. PETER &amp; PAUL</u>			
				24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>			
DATE REC'D BY LOCAL REG. <u>OCT 26 1954</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Kutia 2906 Grand</u> ADDRESS			

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

MON - UNTIL 7:30 P.M.  
TUE 12 - 4:30 P.M.  
Jc 1/270

**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 *James C. Hill*

Licensed Embalmer No. *434*

P. O. Address *2906 Hill*

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.