

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39218  
State File No. ....  
8724  
Registrar's No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY OR TOWN <b>St. Louis, Missouri</b>	c. LENGTH OF STAY (in this place) <b>12 hrs</b>	c. CITY OR TOWN <b>Clayton</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>20 Southmoor Drive</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>ROY</b>	b. (Middle) <b>PHILIP</b>	c. (Last) <b>SCHOLZ</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>9 24 54</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	8. DATE OF BIRTH <b>April 21, 1879</b>	9. AGE (In years last birthday) (Specify) <b>75</b>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physican</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Dr. Philip Scholz</b>	13b. MOTHER'S MAIDEN NAME <b>Florence Belle Scholz</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>unk</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Miss Amy Scholz-20 Southmoor Drive</b>	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Brain Hemorrhage</b>		<b>16 hrs</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardiovascular disease</b> DUE TO (c)		<b>5 years</b>
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"/>
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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)
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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? <b>443x</b>
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22. I hereby certify that I attended the deceased from **Sept. 21, 1952, to Sept. 24, 1954**, that I last saw the deceased alive on **Sept. 24, 1954**, and that death occurred at **2:00a m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>John J. Rath</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>634 N. Grand Blvd.</b>	23c. DATE SIGNED <b>9-24-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>9-25-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>SEP 24 1954</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>C. R. Lupton &amp; Sons-7233 Delmar Blv'd.</b>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 H. Mu*.....

Licensed Embalmer No. *40*.....  
P. O. Address *H. Lewis*.....

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.