

FILED JUN 27 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20392

State File No. 5278
Registrar's No. 5278

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. 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. LENGTH OF STAY (in this place) _____
c. CITY OR TOWN St Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION 4408 West Florissant
STREET ADDRESS (If rural, give location) 4408 West Florissant 2099/6

3. NAME OF DECEASED (Type or Print) a. (First) Eva b. (Middle) _____ c. (Last) Schriber
4. DATE OF DEATH (Month) (Day) (Year) June 17 1955

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH Mar 5, 1870
9. AGE (In years last birthday) 85 IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work producing most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (City and State or Foreign Country) Hillsboro Ill 12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME Sylvester Stephenson 13b. MOTHER'S MAIDEN NAME Unknown 14. NAME OF HUSBAND OR WIFE Clem Schriber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Grace Ashby 4408 West Florissant ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Labor Pneumonia
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis
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 4 days 4 yrs

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____
20. AUTOPSY? YES NO

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 NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from June 17, 1955, to June 17, 1955, that I last saw the deceased alive on June 17, 1955, and that death occurred at 6:00 p.m. from the causes and on the date stated above. 490x

23. SIGNATURE (Degree or title) _____ 23b. ADDRESS 4119 W Florissant St
23c. DATE SIGNED 6/18/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 6-18-55
24c. NAME OF CEMETERY OR CREMATORY 24d. LOCATION (City, town, or county) (State) Litchfield Ill

DATE REC'D BY LOCAL REG. JUN 18 1955 REGISTRAR'S SIGNATURE J. Paul Smith, M.D.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington

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 embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Paul A. Wachter*

Licensed Embalmer No. *478*

P. O. Address *St. 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.