

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35129**  
Registrar's No. **8801**

FILED OCT 24 1955

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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>39</b>		e. STREET ADDRESS (If rural, give location) <b>3620 Clarence Avenue</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3620 Clarence Avenue</b>		f. STREET ADDRESS <b>3620 Clarence Avenue</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Andrew</b>	b. (Middle) <b>L.</b>	c. (Last) <b>Schaefer</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>10 - 7 - 1955</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>Married</b>	8. DATE OF BIRTH <b>2 - 24 - 1882</b>	9. AGE (in years last birthday) <b>73</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Company President</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Supply &amp; Wrecking Co.</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>Jacob Schaefer</b>	13b. MOTHER'S MAIDEN NAME <b>Dorothy Wipke</b>	14. NAME OF HUSBAND OR WIFE <b>Millie Reitz Schaefer</b>
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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.	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Andrew L. Schaefer</b>	ADDRESS <b>3620 Clarence Avenue</b>
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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, asthenia, 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>Arteriosclerotic heart dis</b>		<b>years</b>
	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. <b>Generalized arteriosclerosis - yrs</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>420-0</b>	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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **July 12, 1952** to **Oct. 10, 1953**, that I last saw the deceased alive on **Sept. 11, 1953**, and that death occurred at **6:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Burille Eck (M.D.)</b>	(License or title)	23b. ADDRESS <b>308 N. Grand</b>	23c. DATE SIGNED <b>Oct. 10, 1953</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>10/10/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Mausoleum</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>
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DATE REC'D BY LOCAL REG. <b>OCT 10 1955</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Drehmann-Harral</b>	ADDRESS <b>1905 Union Blvd.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. B. Eck  
508 N. Grand

Mon. 9 - 11

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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 *Albert R. Thompson*

Licensed Embalmer No. *423*

P. O. Address *H. J. ...*

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.