

FILED NOV 23 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38827

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** State File No. _____
Registrar's No. **10041**

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, write RURAL and give town) **St. Louis** c. LENGTH OF STAY (In this place) **1 DAY**
d. FULL NAME OF HOSPITAL OR INSTITUTION **Luthern Hosp.**
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE **Missouri** b. COUNTY _____
c. CITY OR TOWN **St. Louis** d. Is Residence within limits of a city or incorporated town? Yes No
e. STREET ADDRESS (If rural, give location) **4057 Haven**

3. NAME OF DECEASED (Type or Print) a. (First) **CLARA** b. (Middle) _____ c. (Last) **SCHARPENBURG**
4. DATE OF DEATH (Month) (Day) (Year) **11-16-1955**
5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Widowed** 8. DATE OF BIRTH **5-10-1875**
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 14 HRS. Hours Min. **80-6-6**
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) **at home** 10b. KIND OF BUSINESS OR INDUSTRY **Home Work** 11. BIRTHPLACE (City and State or Foreign Country) **St, Louis Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Bernhart Moehlenhof** 13b. MOTHER'S MAIDEN NAME **Mary Schleit** 14. NAME OF HUSBAND OR WIFE **Deceased**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, year or dates of service) **No** 16. SOCIAL SECURITY NO. **none** 17. INFORMANT'S SIGNATURE OR NAME **Hattie Hildebrand** ADDRESS **7212 Morgenford Rd**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Cardio - Vasculan Disease**
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES DUE TO (b) **Arterio Sclerosis**
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. **422.1**
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 May 16, 1953, to May 16, 1953, that I last saw the deceased alive on May 16, 1953, and that death occurred at 11 AM m., from the causes and on the date stated above.

23a. SIGNATURE **H. Schmeisser** (Degree or title) **MD** 23b. ADDRESS **68116 Grand Ave** 23c. DATE SIGNED **11/17/55**
24a. BURIAL, CREMATION, or other disposition **Removed** 24b. DATE **11-19-1955** 24c. NAME OF CEMETERY OR CREMATORY **Mt. Hope Mausoleum** 24d. LOCATION (City, town, or county) (State) **St. Louis Co. Mo**

DATE REC'D BY LOCAL REG. **NOV 17 1955** REGISTRAR'S SIGNATURE **Carl Smith MD** FUNERAL DIRECTOR'S SIGNATURE **WINGBERMUEHLE** ADDRESS **3819 So Grand Blvd**

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 *Geo. O. Krummholz*

Licensed Embalmer No. *461*

P. O. Address *Adm 18*

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.