

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11755

State File No.

FILED APR 12 1956

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 542 Registrar's No. 260

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN Ferguson		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 1 yr.		d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Halls Ferry Nursing Home		e. STREET ADDRESS (If rural, give location) 7821 St. Charles Rd.	

3. NAME OF DECEASED (Type or Print) Sophie	a. (First)	b. (Middle)	c. (Last) Epp	4. DATE OF DEATH 3/18/56	(Month)	(Day)	(Year)
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1/13/1870	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Missouri	12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Geo. Scheu	13b. MOTHER'S MAIDEN NAME Marie Gauss	14. NAME OF HUSBAND OR WIFE Geo. Epp Dec.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Rose Anderson	ADDRESS 8003 Allen Ave.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardia		
	ANTECEDENT CAUSES vascular disease		
DUE TO (b) _____		unknown	
DUE TO (c) _____		unknown	
II. OTHER SIGNIFICANT CONDITIONS Blind, deaf.		unknown	
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) 4221 (COUNTY) (STATE)
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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?
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22. I hereby certify that I attended the deceased from May 15, 1955, to March 18, 1956, that I last saw the deceased alive on March 13, 1956, and that death occurred at 11:55p., from the causes and on the date stated above.

23a. SIGNATURE Lewis Litzmann (Degree or title) MD	23b. ADDRESS 8231 Clayton Rd (17)	23c. DATE SIGNED 3/19/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/21/56	24c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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DATE REC'D BY LOCAL REG. 3-19-56	REGISTRAR'S SIGNATURE Herbert B. Douber	25. FUNERAL DIRECTOR'S SIGNATURE Jos. W. Clark	ADDRESS Clark Funeral Home I. C. 1125 Bodiamont Ave.
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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 em
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Alfred J. Brudeker*.....
Licensed Embalmer No. *26*

P. O. Address *11257+*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (1)
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.