

FILED SEP 19 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32793**

BIRTH NO. _____		REG. DIST. NO. <b>317</b>		PRIMARY REG. DIST. NO. <b>500</b>		Registrar's No. <b>1920</b>	
1. PLACE OF DEATH a. COUNTY <b>St Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY _____			
b. CITY OR TOWN <b>St Louis</b>		c. LENGTH OF STAY (in this place) <b>3 mo</b>		c. CITY OR TOWN <b>St. Louis</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>Robert Koch Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>5346 Chippewa</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Benjamin</b>			b. (Middle) <b>L.</b>		c. (Last) <b>Shroeder JR.</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Aug 8 56</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>		8. DATE OF BIRTH <b>6-2-18</b>	9. AGE (In years last birthday) <b>38</b>	UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	IF UNDER 12 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Benjamin Shroeder Sr</b>			13b. MOTHER'S MAIDEN NAME <b>Not known</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Army WWI</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT'S SIGNATURE OR NAME <b>RFS record</b> ADDRESS _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Tuberculosis Pulmonary</b>		ANTECEDENT CAUSES					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <b>Brain Tumor</b>					
		DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death. <b>Brain Tumor</b>					
19a. DATE OF OPERATION <b>8-2-56</b>		19b. MAJOR FINDINGS OF OPERATION <b>TBC &amp; Cavitation of RUL</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>5-1</b> , 19 <b>56</b> , to <b>8-8</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8-8</b> , 19 <b>56</b> , and that death occurred at <b>1:45 p.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Bernard Friedman, M.D.</b>				23b. ADDRESS <b>Koch Hospital, Koch, Mo.</b>		23c. DATE SIGNED <b>8-8-56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>8/10/56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>LOUISVILLE, KENTUCKY</b>	
DATE REC'D BY LOCAL REG. <b>8-10-56</b>		REGISTRAR'S SIGNATURE <b>Herbert A. Dombek</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>PROVOST UND. Co., 3710 N. GRAND.</b> ADDRESS _____			

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 *Gustav W. Deibert*.....

Licensed Embalmer No. *4329*.....

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.