

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 16 1956

State File No. **36135**
9429
Registrar's No.

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

BIRTH NO.

REG. DIST. NO.

PRIMARY REG. DIST. NO.

Registrar's No.

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|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY | | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Louis | | c. LENGTH OF STAY (in this place) 44 DAYS | c. CITY OR TOWN St. Louis | | 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 St. Anthonys | | | e. STREET ADDRESS (If rural, give location) 201 1/2 603 Holly Hills | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Arlene | | b. (Middle) | c. (Last) Schaefer | 4. DATE OF DEATH (Month) (Day) (Year) Oct. 14 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED/ WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Jan. 4 1938 | 9. AGE (In years) (If under 1 year: Months) (Days) 18 | 10. IF UNDER 1 YEAR: Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse Work | | 10b. KIND OF BUSINESS OR INDUSTRY at Home | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13a. FATHER'S NAME Ruben Von Falge | | 13b. MOTHER'S MAIDEN NAME Regina Sligros | | 14. NAME OF HUSBAND OR WIFE Lawrence | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 486-38-9508 | 17. INFORMANT'S SIGNATURE OR NAME, ADDRESS Lawrence Schaefer 603 Holly Hills | | |
| 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. | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Internal Hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs. |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ruptured Ectopic Pregnancy | | DUE TO (c) |
| 19a. DATE OF OPERATION 10-14-56 | 19b. MAJOR FINDINGS OF OPERATION Ruptured Ectopic Pregnancy | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.) |
| 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 10-13, 1956 , to 10-15, 1956 , that I last saw the deceased alive on 10-15, 1956 , and that death occurred at 2:30 P. m. , from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE (Degree or title) Robert A. Brennan M.D. | | | 23b. ADDRESS 3606 Brown | | 23c. DATE SIGNED 10-16-56 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 10/17/56 | 24c. NAME OF CEMETERY OR CREMATORY Resurrection | | 24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. | |
| DATE REC'D BY LOCAL REG. OCT 16 1956 | REGISTRAR'S SIGNATURE Carl Smith Mo | | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS JOS. P. FENDLER JR. 7128 MICHAEL | | |

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 *Clarence Kuchow*
Licensed Embalmer No. *3093*
P. O. Address *7128 Michigan*

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.