

Health, Welfare  
Public  
Service

300  
1-56

ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

FILED NOV 7 - 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **36569**

Registration District No. **317** Primary Registration District No. **547** Registrar's No. **2540**

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>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Hts.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>University City Mo</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>		Length of stay in lb <b>4 Day's</b>	d. STREET ADDRESS (If outside, give location) <b>1501 Lyndale</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Malvina S. Hofstetter</b>	First <b>Malvina</b> Middle <b>S.</b> Last <b>Hofstetter</b>	4. DATE OF DEATH <b>Oct. 26 1956</b>	Month <b>Oct.</b> Day <b>26</b> Year <b>1956</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 15 1887</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Millinery Scheuer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Florence Shop</b>	11. BIRTHPLACE (City and state or country) <b>Manchester, MO</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
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13. FATHER'S NAME <b>Dr. George Scheuer</b>	14. MOTHER'S MAIDEN NAME <b>Mary Herzog</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. <b>490-10-9912</b>	17. INFORMANT <b>Mrs Inez Leibold 1501 Lyndale U City</b>	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>A.S. C.V.R. disease</b>	<b>Uncertain</b>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <b>None</b>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>
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20c. TIME OF INJURY Hour <b>---</b> Month <b>---</b> Day <b>---</b> Year <b>---</b> a. m. <b>---</b> p. m. <b>---</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>---</b>	20f. CITY, TOWN, OR LOCATION <b>---</b>	COUNTY <b>---</b>	STATE <b>---</b>
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21. I attended the deceased from <b>Febr 17, 1890</b> <b>Oct. 26, 1956</b> and last saw her alive on <b>Oct. 26, 1956</b> Death occurred at <b>3:15P</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Henry E. Oppenheimer, M.D.</b>	22b. ADDRESS <b>35 W. Central Ave., Clayton 5<sup>th</sup></b>	22c. DATE SIGNED <b>Oct. 27, 1956</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bury</b>	23b. DATE <b>10-29 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>St. Louis County Mo.</b>
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24. FUNERAL DIRECTOR <b>Fred C. Henke 4911 Washington Blvd</b>	ADDRESS <b>4911 Washington Blvd</b>	25. DATE RECD. BY LOCAL REG. <b>10-29-56</b>	26. REGISTRAR'S SIGNATURE <b>Herbert B. Dombke, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr.

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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 *Elmo R. Sadwell*.....

Licensed Embalmer No. *40*

P. O. Address *St. Louis*.....

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