

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11010

STATE FILE NUMBER

FILED APR 12 1957

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2127

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hosp.</u>			Length of stay in lb		4. STREET ADDRESS (If outside, give location) <u>2187 3666 Laclede Av.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Marie</u> Last <u>Schaefer</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 12 1889</u>	
9. AGE (In years last birthday) <u>67</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u>4</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Germany</u>	
13. FATHER'S NAME <u>Gustav Hoff</u>				14. MOTHER'S MAIDEN NAME <u>Conradina Cullen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>no.</u>		17. INFORMANT Address <u>Anna Lee Sauerland 3666 Laclede</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post operative intracranial Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acoustic nerve neurone;</u> DUE TO <u>fractured Right hip;</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Suffered in fall at home</u>				
20c. TIME OF INJURY Hour <u>2</u> a. m. <u>7:57</u> Month, Day, Year <u>July 7, 1957</u>			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION <u>St. Louis Mo 21</u> COUNTY <u>Mo</u> STATE <u>21</u>				
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>708 A</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>James M Kelly</u> (Deputy or title) <u>Deputy</u>				22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>3-4-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>Mar. 4 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mo. Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>	
24. FUNERAL DIRECTOR <u>Will Bro. Co. No. 2929 S. Jefferson</u>				25. DATE RECD. BY LOCAL REG. <u>MAR 4 '57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith, Mo</u> <u>m83</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service

S. 300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

DEC 5 1957

**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 Not Embalmed Student Embalmer No. \_\_\_\_\_ working under my personal supervision..

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harold C. Witt

Licensed Embalmer No. 435

P. O. Address 2929 S. Jell

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.