

FILED MAR 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE 11019

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2285

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2151 Angelica			Length of stay in lb		d. STREET ADDRESS 2151 Angelica St.		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Karl Middle A. Last Scheible			4. DATE OF DEATH Month March Day 5, Year 1957						
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 9, 1873		9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist			10b. KIND OF BUSINESS OR INDUSTRY Fulton Iron Works		11. BIRTHPLACE (City and state or country) Scharmbach, Germany		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frederick Scheible				14. MOTHER'S MAIDEN NAME Mary —					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Miss Gertrude Scheible 2151 Angelica St.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. Bronchitis and asthma DUE TO (b) Chr. Myocarditis DUE TO (c) Chr. Myocarditis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post Operative Hernia, Chr. leg ulcer 5021.							INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT <input 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.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from 1927 to March, 1957 and last saw her alive on Jan 27 1957 Death occurred at 7:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Walter C. Kirchner M.D. 508 N. Grand St. (3)			22b. ADDRESS 508 N. Grand			22c. DATE SIGNED 3/7/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 3-8-57	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory			23d. LOCATION (City, town, or county) (State) St. Louis Co, Missouri.			
24. FUNERAL DIRECTOR Math Hermann & Son, Inc. 2161 E. Fair				ADDRESS		25. DATE RECD. BY LOCAL REG. MAR 7 '57		26. REGISTRAR'S SIGNATURE Carl Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
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

MEDICAL CERTIFICATION

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 *Clement McNeary*.....

Licensed Embalmer No. *375*

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.