

FILED MAR 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 560Health,
& Welfare
Public
ServiceS. 300
v. 1-56All
causes

Securing the medical certification in the specific manner required by R.S. MO. MO. 1947.

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | |
|--|----------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Monroes</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ferguson</u> | | | Inside Limits Yes# No <input type="checkbox"/> | c. CITY OR TOWN <u>Monroe City 0690</u> | | Inside Limits Yes# No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>10 N. Barat</u> | | | Length of stay in lb <u>4 days</u> | d. STREET ADDRESS <u>-----</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Anna</u> Last <u>Karcher</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>1</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>June 25, 1870</u> | | 9. AGE (In years last birthday) <u>86</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 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 <u>Home</u> | 11. BIRTHPLACE (City and state or country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME <u>George Schmidt</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mrs. Bell, Ferguson, Missouri.</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>Senile degenerative cardio-vascular renal disorder</u> DUE TO (b) _____ DUE TO (c) _____ 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) <u>Cerebrovascular disease & gradual paralysis of extremities</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u> yrs.</u> |
| 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.) | | | | |
| 20c. TIME OF INJURY Hour _____ 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 <u>442x</u> | | 20g. COUNTY <u>Monroe</u> | |
| 20h. STATE <u>Mo.</u> | | 21. I attended the deceased from <u>2/4/57</u> to <u>2/1/57</u> and last saw her/him alive on <u>2/29/57</u> Death occurred at <u>2:30 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Arthur A. Gandy MD</u> | | | 22b. ADDRESS <u>111 Churck Ferguson Mo</u> | | | 22c. DATE SIGNED <u>2/1/57</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>3-1-57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Monroe City, Mo.</u> | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>White-Chapel, Ferguson, Mo.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>3/1/57</u> | | 26. REGISTRAR'S SIGNATURE <u>Herbert B. Donhe MD</u> | | |

(Licensed Embalmer's Statement on Reverse Side)

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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 *E. Lewis Brown*.....

Licensed Embalmer No. *340*

P. O. Address *.....*

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.