

FILED MAY 24 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19248**
Registrar's No. **4321**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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, write RURAL and give township) OR TOWN **St. Louis** c. LENGTH OF STAY (In this place) _____
c. CITY OR TOWN **St. Louis** d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION **St. Johns Hospital** e. STREET ADDRESS (If rural, give location) **2904 St. Vincent**

3. NAME OF DECEASED. a. (First) **George** b. (Middle) **V** c. (Last) **Schaefer** 4. DATE OF DEATH (Month) (Day) (Year) **May 4 1957**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Widowed** 8. DATE OF BIRTH **Jan 24 1877** 9. AGE (In years last birthday) **80** IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Mins. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Baker** 10b. KIND OF BUSINESS OR INDUSTRY **Own Bakery** 11. BIRTHPLACE (City and State or Foreign Country) **Illinois** 12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **Mathias Schaefer** 13b. MOTHER'S MAIDEN NAME **Margaret Unknown** 14. NAME OF HUSBAND OR WIFE **Agnes Keane**

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'S SIGNATURE OR NAME **Estelle Schaefer** ADDRESS **2904 St. Vincent**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Cerebral Thrombosis** INTERVAL BETWEEN ONSET AND DEATH **5 days**

II. ACCIDENT CAUSES **Ans. Schomic**

III. OTHER SIGNIFICANT CONDITIONS **332x**

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR _____

22. I hereby certify that I attended the deceased from **5-3-57** to **5-4-57**, 1957, that I last saw the deceased alive on **3-3-1927**, and that death occurred at **6:15** m., from the causes and on the date stated above.

23a. SIGNATURE **Carl Weiss MD** (Name or title) 23b. ADDRESS **18th Kingshighway** 23c. DATE SIGNED **5-6-57**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **May 6 57** 24c. NAME OF CEMETERY OR CREMATORY **Calvary** 24d. LOCATION (City, town, or county) (State) **St. Louis Mo**

DATE RECD BY LOCAL REG. **MAY 6 57** REGISTRAR'S SIGNATURE **E.J. Schnur MD** 25. FUNERAL DIRECTOR'S SIGNATURE **E.J. Schnur** ADDRESS **3125 Lafayette**

mjs (Licensed Embalmer's Statement on Reverse Side)

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 *Joseph B. Williams*
Licensed Embalmer No. *21914*

P. O. Address *3125 Galtway*

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.