

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 27 1957

42570
STATE FILE NUMBER
10091

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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 SAINT LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SAINT LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 4564 PLOVER AVE.		Length of stay in lb LIFE	229 STREET ADDRESS (If outside, give location) 4564 PLOVER AVE. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPHINE - - - SCHARF			4. DATE OF DEATH Month Day Year OCT. 26, 1957.
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 17, 1873
9. AGE (In years last birthday) 84		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) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME JOHN FELDOTTO	
14. MOTHER'S MAIDEN NAME JOHANNA (LAST UNKNOWN)		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 MRS. MARIE FISCHER, 9421 PICKFORD PL. 21	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) chronic coronary occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) chronic arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4201			INTERVAL BETWEEN ONSET AND DEATH 6 mo 5 yrs 9
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 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 Sept 4, 1956 to Oct. 26, 1957 and last saw her alive on Oct. 19, 1957 Death occurred at 11 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Eugene L. Arnold M.D.		22b. ADDRESS 8700 Partridge	22c. DATE SIGNED 10/26/57
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY.	23d. LOCATION (City, town, or county) (State)
BURIAL	10/29/57	CALVARY CEMETERY	ST. LOUIS, MO.
24. FUNERAL DIRECTOR ADDRESS CALVIN F. FEUTZ, 4828 NATURAL BRIDGE BL.		25. DATE RECD. BY LOCAL REG. OCT. 28 '57	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.

12001

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 *Raymond L. Jones*.....

Licensed Embalmer No. 427.

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.