

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-006880  
State File No.

FILED FEB 17 1958

|  |  |   |   |  |
|--|--|---|---|--|
| BIRTH NO.  |  | REG. DIST. NO. <u>310</u>   | PRIMARY REG. DIST. NO. <u>3058</u>  | Registrar's No. <u>39</u>  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>St Charles</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE<br><u>Missouri</u><br>b. COUNTY<br><u>St Charles</u>   |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>St Charles</u>  |  | c. CITY OR TOWN<br><u>St Charles</u>  |   | d. If residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (In this place)<br><u>2 1/2</u> S  |  | e. STREET ADDRESS (If rural, give location)<br><u>905 Jefferson St</u>  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>St Joseph Hospital</u>   |  |   |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First)<br><u>Emmons</u>  |  | b. (Middle)<br><u>Schorfheide</u>   |   | c. (Last)<br><u>Schorfheide</u>  |
| 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>Feb. 8 1958</u>   |  |   |   |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>  | 8. DATE OF BIRTH<br><u>1910 Jan 22 1958</u>   | 9. AGE (In years last birthday)<br><u>48</u><br>IF UNDER 1 YEAR: Months _____ Days _____<br>IF UNDER 24 HRS.: Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Meta Worker</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Aircraft</u>  |   | 11. BIRTHPLACE (City and State or Foreign Country)<br><u>Marthasville Mo</u>   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |   |   |  |
| 13a. FATHER'S NAME<br><u>August Schorfheide</u>  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Helen Lippold</u>   |   | 14. NAME OF HUSBAND/OR WIFE<br><u>Della Schorfheide</u>  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>497-10-8226</u>   |   | 17. INFORMANT'S SIGNATURE OR NAME<br><u>Mrs Della Schorfheide</u>  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.   |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemorrhagic Pancreatitis</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Cholelithiasis, hepatitis, cholangitis</u><br>DUE TO (c) <u>+</u> |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u>  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>hemorrhage + shock</u>   |  |   |   | <u>2 days</u>  |
| 19a. DATE OF OPERATION<br><u>2/5/58</u>  | 19b. MAJOR FINDINGS OF OPERATION<br><u>cholecystitis, cholelithiasis, inflammation</u>                 |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)<br><u>SUICIDE</u>   | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br><u>St Charles Mo</u>             |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>m.  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <u>2/4</u> , 19 <u>58</u> , to <u>2/8</u> , 19 <u>58</u> that I last saw the deceased alive on <u>2/5</u> , 19 <u>58</u> , and that death occurred at <u>2:00</u> p.m., from the causes and on the date stated above. |  |   |   |  |
| 23a. SIGNATURE<br><u>Dr. Newberger</u>   |  | 23b. ADDRESS<br><u>St Charles Mo</u>  |   | 23c. DATE SIGNED<br><u>2/11/58</u>   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 24b. DATE<br><u>Feb. 11 1958</u>   | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Grove Cemetery</u>   | 24d. LOCATION (City, town, or county) (State)<br><u>St Charles Mo.</u>              |  |
| DATE REC'D BY LOCAL REG.<br><u>FEB 11-58</u>   | REGISTRAR'S SIGNATURE<br><u>Margaret Wilson</u>  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Arthur C. Bone</u>   |   | ADDRESS<br><u>St Charles Mo</u>  |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
Corr. by Aff. July 17, 1958

FEB 20 1958

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.....  
*Arthur C. Bane*

Licensed Embalmer No. *3157*

P. O. Address *St. Charles*

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.