

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023715
STATE FILE NUMBER

FILED JUN 27 1958

Registration District No. 318 Primary Registration District No. 1003

1003

Registrar's No. 6154

300
1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		c. CITY OR TOWN St Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros.		d. STREET ADDRESS (If outside, give location) 4249 Iowa	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph C Schall		4. DATE OF DEATH Month Day Year June 15, 1958	
5. SEX male <input type="radio"/>	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 Apr 25, 1897
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done in present or working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Brewery worker	11. BIRTHPLACE (City and state or country) St Louis Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Joseph Schall	
13b. MOTHER'S MAIDEN NAME Augusta Schroeder		14. NAME OF HUSBAND OR WIFE Anna Schall	
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.	17. INFORMANT Address Anna Schall 4249 Iowa
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cerebral 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). 332x			INTERVAL BETWEEN ONSET AND DEATH 4 days 1 yrd.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 <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.) St. Louis Mo	
21. I attended the deceased from Death occurred at Jan 12:15 1954 to 6/15/58 and last saw him alive on 6/14/58.		22a. SIGNATURE (Degree or title) Runezera Ind	
22b. ADDRESS 8059 Watson Rd		22c. DATE SIGNED 6/6/58	
23a. BURIAL, CREMATION, REINQUAN (Specify) Burial		23b. DATE 6/18/58	
23c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cem.		23d. LOCATION (City, town, or county) (State) St Louis Mo.	
24. FUNERAL DIRECTOR ADDRESS J L Ziegenhein & Sons 7027 Gravois		25. DATE RECD. BY LOCAL REG. JUN 17 '58	
26. REGISTRAR'S SIGNATURE Pearl Smith mo		27. m KB.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

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 Donald E. Baum
Licensed Embalmer No. 4823
P. O. Address St. Louis, Mo.

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.