

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024199
STATE FILE NUMBER

FILED JUL 14 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1796

1. PLACE OF DEATH a. COUNTY St. Louis		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 ARBOR TERRACE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mother of Good Council		Length of stay in lb 12da	d. STREET ADDRESS (If outside, give location) 4615 Lindell Blvd Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CLARA		First R. Middle Schnepf Last	4. DATE OF DEATH Month 7 Day 6 Year 1958
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1878
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) Romania
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Aaron Rabinovici	
13b. MOTHER'S MAIDEN NAME Judith Nadler		14. NAME OF HUSBAND OR WIFE Isadore Schnepf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 498-03-4939	17. INFORMANT Address Mrs. Joseph Grand 821 Cella Rd
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Generalized Carcinomatosis DUE TO (c) Carcinoma of Ampulla of Vater			INTERVAL BETWEEN ONSET AND DEATH 48 hours 8 months 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (e) 1551			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 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 July 5, 1958 and last saw her alive on July 5, 1958 Death occurred at 7:30 a.m. July 6, 1958 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE, (Name or title) William N. Blalock MD		22b. ADDRESS 114 W. Taylor Ave. St. Louis, Mo.	
22c. DATE SIGNED 7/7/58		23a. LOCATION (City, town, or county) (State) St. Louis Mo.	
23b. DATE 7/7/58		23c. NAME OF CEMETERY OR CREMATORY B. Nat Amoons	
23d. BURIAL, CREMATION, REMOVAL (Specify) Burial		23e. NAME OF FUNERAL HOME Mayer	
24. FUNERAL DIRECTOR Mayer		25. DATE RECD. BY LOCAL REG. 7-7-58	
26. REGISTERAR'S SIGNATURE Herbert R. Donke M.D.		27. (Licensed Embalmer's Statement on Reverse Side)	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300
1-57

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 *Laurence O. Gerling*

Licensed Embalmer No. *4979*
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.