Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-042219
STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11274

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 2309a Shenandoah — Length of stay in 1b 239

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 2309a Shenandoah St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Wilma Middle Schreiner

4. DATE OF DEATH Month Nov. Day 22 Year 1958

5. SEX Female 1
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Aug. 8, 1901
9. AGE (In years last birthday) 57 — IF UNDER 1 YEAR Months 3 Days 14 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (City and state or country) Yugoslavia 6
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Michial Hen
13b. MOTHER'S MAIDEN NAME Anna Brook
14. NAME OF HUSBAND OR WIFE Joseph Schreiner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Joseph Schreiner Address 2309a Shenandoah St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Kachexia — INTERVAL BETWEEN ONSET AND DEATH 8 Month
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Bronchogenic Carcinoma — 12 Month
DUE TO (c) 162.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 August 30th 58, to 11/22/58 and last saw her alive on 11-18-58
Death occurred at 5:00 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ernest Younger, M.D. (Degree or title)
22b. ADDRESS 3624 Russell
22c. DATE SIGNED 11-24-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 11/24/58
23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery
23d. LOCATION (City, town, or county) St. Louis County (State) Mo.

24. FUNERAL DIRECTOR Gebken Sons ADDRESS 2630 Gravois Av.
25. DATE RECD. BY LOCAL REG. NOV 24 '58
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.R.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 ..... Signed W E Morris

Signature of Student Embalmer

Licensed Embalmer No. 3360

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.