

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011360

STATE FILE NUMBER

2872

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

**FILED APR 10 1959**

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY _____  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY _____                                |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>DOA City Hospital</b>   |   | Length of stay in 1b _____  | d. STREET ADDRESS (If outside, give location)<br><b>5938 Emma Ave.</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>FREDERICK SCHAFFERS</b>   |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Mar. 20 1959</b>   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Mar. 23 1886</b>   |
| 9. AGE (In years last birthday)<br><b>72</b>  |   | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HRS.<br>Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Iron Moulder</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Fulton Iron</b>   | 11. BIRTHPLACE (City and state or country)<br><b>Neuheim Germany 4</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 13a. FATHER'S NAME<br><b>Frank Schafers</b>   |   |
| 13b. MOTHER'S MAIDEN NAME<br><b>Katherine Duppelman</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Frieda Schafers</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO.<br><b>494-10-1020</b>   | 17. INFORMANT Address<br><b>Theodore Schafers 6735 Mathew</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arterio Sclerosis</b><br>DUE TO (c) <b>331X</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| 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?<br>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<br>Hour _____<br>a.m. _____<br>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.)  | 20f. CITY, TOWN, OR LOCATION  | COUNTY  | STATE   |
| 21. Attended the deceased from _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.  |   |   |   |
| 22a. SIGNATURE<br><i>James M. Leonard</i> (Copy or title) _____ 3   |   | 22b. ADDRESS<br><b>1300 Clark</b>   | 22c. DATE SIGNED<br><b>3/21/59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>3/23/59</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>   | 23d. LOCATION (City, town, or county)<br><b>St. Louis Mo.</b>   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Buchholz Mortuary 5967 W. Florissant</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>MAR 21 '59</b>   | 26. REGISTRAR'S SIGNATURE<br><i>Earl Smith, M.D.</i>  |

300  
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

7

2. 11

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 *Walter W. Beckler* .....

Licensed Embalmer No. *4551* .....

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.