Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015675

STATE FILE NUMBER

FILED APR 20 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 3205

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
d. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) City Hosp/ — Length of stay in lb 21 days	d. STREET ADDRESS (If outside, give location) 4555 S. Broadway — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First Emil	Middle G.	Last Schiefelbein	4. DATE OF DEATH Month Day Year 3/30/59
5. SEX M	6. COLOR OR RACE W	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	8. DATE OF BIRTH 6/18/1883
9. AGE (In years last birthday) 75	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) printer	10b. KIND OF BUSINESS OR INDUSTRY Chris. Bd. Pub.	11. BIRTHPLACE (City and state or country) St/ Louis Mo.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Karl Schiefelbein	13b. MOTHER'S MAIDEN NAME Louise Brandt	14. NAME OF HUSBAND OR WIFE Leela (deceased)	
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. 492-05-3951	17. INFORMANT Anita Zimmerli	Address 4555 S. B'way

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) Fracture of Left Hip

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteria Sclerosis

DUE TO (c) E 904.0

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? YES [ ] NO [X]

20a. ACCIDENT [X] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Suffered in fall in Home

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 3 10 59 March 10th 1959

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.) 156 Home

20f. CITY, TOWN, OR LOCATION St Louis COUNTY Mo STATE

21. I attended the deceased from ....., to ..... and last saw her/him alive on .....

Death occurred at 2 40 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Patrick Claylor Carmer	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 3.31.59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4/1/59	23c. NAME OF CEMETERY OR CREMATORY Concordia	23d. LOCATION (City, town, or county) St. Louis (State) Mo.
24. FUNERAL DIRECTOR Schumacher	ADDRESS 3013 Meramec	25. DATE RECD. BY LOCAL REG. MAR 31 '59	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

M.J.B.

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 .....
Signature of Student Embalmer

Signed .....Jack Haupt.....

Licensed Embalmer No. 4746

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.