

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023364

FILED JUL 7 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ STATE FILE NUMBER 5997  
Registrar's No. \_\_\_\_\_

S. 300

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hospital</b>		Length of stay in lb <b>2mo 17dys</b>	d. STREET ADDRESS (If outside, give location) <b>6321 Ouida</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ben</b> Middle <b>J.</b> Last <b>Schaefer</b>			4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1959</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1888</b>	9. AGE (In years last birthday) <b>71</b>	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) <b>Building Contractor (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>John Schaefer</b>		13b. MOTHER'S MAIDEN NAME <b>Katherine Spuering</b>		14. NAME OF HUSBAND OR WIFE <b>Bessie Schaefer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, Unknown) (If yes, in what service of this country) <b>YES (Unknown) 1st World War</b>		16. SOCIAL SECURITY NO. <b>495-36-7600-A</b>		17. INFORMANT Address <b>Mrs. Bessie Schaefer, 6321 Ouida Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 mo.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) <b>Generalized Arteriosclerosis</b>					<b>2 1/2 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>					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 _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>Apr. 6, 1959</b> to <b>June 23, 1959</b> and last saw her alive on <b>June 23, 1959</b> Death occurred at <b>10:15 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>			22b. ADDRESS <b>5800 Arsenal</b>		22c. DATE SIGNED <b>6/24/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>June 23, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair</b>			25. DATE RECD. BY LOCAL REG. <b>JUN 25 '59</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>	

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *W. J. Craft & Burnley* .....

Licensed Embalmer No. *47209* .....

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.