

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034700

FILED VS SEP 21 1959

317

Primary Registration District No. 547

Registrar's No. 2304

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <i>ST LOUIS</i>		Length of stay in 1b <i>1 HR.</i>		a. STATE <i>MO.</i>		b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <i>RICHMOND HEIGHTS</i>		c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. MARY'S HOSPITAL</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>1007 ALLEN AVE.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			Month Day Year	
First Middle Last <i>EVA SCHAEFFER</i>			<i>AUG 24 1959</i>				
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>NOV. 3, 1891</i>	9. AGE (last birthday) <i>67</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWORK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DOMESTIC</i>		11. BIRTHPLACE (City and state or country) <i>HUNGARY</i>		12. CITIZEN OF WHAT COUNTRY <i>U-S-A</i>	
13a. FATHER'S NAME <i>PETER HUMMEL</i>		13b. MOTHER'S MAIDEN NAME <i>ANNA GLATT</i>		14. NAME OF HUSBAND OR WIFE <i>CONRAD SCHAEFFER (DECD)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>499-34-3341</i>		17. INFORMANT Address <i>JOHN SCHAEFFER 2864 S MC NAIR</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Pulmonary emboli</i>						<i>1 hr -</i>	
DUE TO (b) <i>Cancer of Gall bladder</i>						<i>?</i>	
DUE TO (c) <i>155.1</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Arteriosclerosis</i>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>X</i>			
20c. TIME OF INJURY Hour a.m. p.m. <i>X</i>	Month, Day, Year <i>X</i>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>X</i>		20f. CITY, TOWN, OR LOCATION <i>X</i>		COUNTY		STATE	
21. I attended the deceased from <i>8/24/59</i> to <i>8/24/59</i> and last saw her <i>alive on 8/24/59</i>		Death occurred at <i>1030</i> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Rommelt MA</i>			22b. ADDRESS <i>416 Linden St</i>			22c. DATE SIGNED <i>8/25/59</i>	
23a. GENERAL CREMATION, REMOVAL <i>REMOVAL</i>		23b. DATE <i>AUG 27 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>RESURRECTION CEM.</i>		23d. LOCATION (City, town, or county) <i>ST. LOUIS MO</i>		
24. FUNERAL DIRECTOR <i>Thomas Kuttis 2906 Gravois</i>		25. DATE RECD. BY LOCAL REG. <i>8-26-59</i>		26. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

James O. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 St. ...

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.