

FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004038

FILED VS FEB 10 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 853** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 days	c. CITY OR TOWN St. Louis 16		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4728a Ray Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last ALVINA M SCHUMACHER			4. DATE OF DEATH Month Day Year Jan. 22, 1960		
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/4/89	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days 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) St. Louis Mo.	
12. CITIZEN OF WHAT COUNTRY USA			13a. FATHER'S NAME Fred Gerlach		
13b. MOTHER'S MAIDEN NAME Lena Kammann			14. NAME OF HUSBAND OR WIFE Deceased		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 491 34 8385		17. INFORMANT Address Hortense Speth 4330 Itaska 16	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Biliary Obstruction (Fibrosis - foreign body reaction)					INTERVAL BETWEEN ONSET AND DEATH 3-4 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Fibrosis of common bile duct.					6-8 wks
DUE TO (c) Granuloma foreign body reaction -					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis - Pneumonia - Pyelonephritis - Hypertension					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 586x	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <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. I attended the deceased from 1/19/60 to 1/23/60 and last saw her/him alive on 1/23/60 Death occurred at 5:50 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Rev. Davis M.D.			22b. ADDRESS 3720 Washington Ave St. Louis		22c. DATE SIGNED 1/25/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1/26/60	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Mausoleum		23d. LOCATION (City, town, or county) (State) Lemay 25 Mo.
24. FUNERAL DIRECTOR ADDRESS Fendler Und. Co. 7420 Michigan Ave. (11)			25. DATE RECD. BY LOCAL REG. JAN 25 1960		26. REGISTRAR'S SIGNATURE Paul Smith. M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Elgon Davis 1 to 5000
St. Louis, Mo.
3720 Washington

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Mi

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.