

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004471

FILED VS FEB 5 1960

317

Primary Registration District No. 547

Registrar's No. 227

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				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>Richmond Heights</b>		Length of stay in 1b <b>8hrs.</b>		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>St. Mary's Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2926 Indiana</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>SCHERMANN</b> Last				4. DATE OF DEATH Month <b>Jan.</b> Day <b>21,</b> Year <b>1960</b>					
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 21, 1960</b>		9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min. <b>8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Richmond Heights</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Henry Schermann</b>			13b. MOTHER'S MAIDEN NAME <b>Agnes Schene</b>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Henry Schermann 2926 Indiana</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>26 weeks gestation</b> DUE TO (b) <b>Premature labor/deliv.</b> DUE TO (c) <b>malformation of uterus</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 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								INTERVAL BETWEEN ONSET AND DEATH	
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. Month, Day, Year		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 <b>1-21-60</b> to <b>1-21-60</b> and last saw <sup>her</sup> him alive on <b>1-21-60</b> Death occurred at <b>4:50 P.M. 1-21-60</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree, or title) <b>Erwin T. Huber, M.D.</b>				22b. ADDRESS <b>111 So. Meramec, Clayton</b>				22c. DATE SIGNED <b>1-22-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 22, 1960.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, County, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>A.H. Bocklage F.H. 6536 Clayton Rd.</b>				25. DATE RECD. BY LOCAL REG. <b>1-22-60</b>		26. REGISTRAR'S SIGNATURE <b>John G. Murphy M.D.</b>			

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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Not Embalmed*  
*J. H. Barblage*

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.