

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-020534

FILED VS MAY 23 1960 09

Registration District No. \_\_\_\_\_ Primary Registration District No. 24935 Registrar's No. \_\_\_\_\_

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>St Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Portage Des Sioux</b>		Length of stay in 1b <b>1 year</b>	c. CITY OR TOWN <b>Portage Des Sioux</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>Commonfield &amp; Dummond</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Commonfield &amp; Dummond</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Marquerite</b> Middle <b>Scholer</b> Last <b>Scholer</b>			4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OF 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>2/7/1895</b>	9. AGE (last birthday) <b>65 years</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>George Schappner</b>		13b. MOTHER'S MAIDEN NAME <b>Agnes Kraber</b>		14. NAME OF HUSBAND OR WIFE <b>John Scholer</b>		
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>UNKNOWN</b>		17. INFORMANT <b>John Scholer - Commonfield &amp; Dummond</b> Address _____		

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 <b>1 hr</b>
IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		
DUE TO (b) <b>Arterial Hypertension</b>		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)		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 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 _____ 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 <b>Apr 4 - 1960</b> to <b>April 30</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>Apr 25, 1960</b> Death occurred at <b>7:30</b> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <b>John J. Shaner M.D.</b>		22b. ADDRESS <b>3720 Washington</b>		22c. DATE SIGNED <b>5-2-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>May 4, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>	
24. FUNERAL DIRECTOR <b>BUCHHOLZ MORT - 5967 W. Florissant Ave</b>		25. DATE RECD. BY LOCAL REG. <b>May 19 - 1960</b> <b>MAY 3 - 60</b>		26. REGISTRAR'S SIGNATURE <b>H.W. [Signature]</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS MAY 28 1960

VS APR 16 1962

STATEMENT BY LICENSED EMBALMER

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Wilford J. Bruch

Licensed Embalmer No. 4551

P. O. Address St. Louis

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.