

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024939

FILED VS JUN 27 1960 318

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003 Registrar's No. 5894 STATE FILE NUMBER

DEED  
 Provided due to several different operations on organ & respiratory system  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Parklane Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2839 So. Third St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>A.</u> Last <u>SCHAIER</u>			4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1902</u>	9. AGE (last birthday) <u>57</u>	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) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>O'Fallon, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John G. Walliser</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine War Hoover</u>		14. NAME OF HUSBAND OR WIFE <u>Late Connie W. Schaiier</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Minnie Strange 3526 Juniata St.</u>				
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) <u>Congestive Heart Failure</u>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Intestinal Obstruction</u> DUE TO (c) <u>Post-operative Adhesions</u>								
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. <u>956.X 46</u> <input type="checkbox"/> Yes <input checked="" 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 _____ 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 <u>6-1-60</u> to <u>6-8-60</u> and last saw her/him alive on <u>6-8-60</u> Death occurred at <u>6:00 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>[Signature]</i> (Degree or title)			22b. ADDRESS <u>1930 Lindell Blvd. St. Louis 8, Mo.</u>			22c. DATE SIGNED <u>6-8-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (Mtr)</u>	23b. DATE <u>June 11, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>College Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lebanon, Ill.</u>				
24. FUNERAL DIRECTOR <u>Kriegshausler 4228 S. Kingshighway Blvd.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>JUN 8 1960</u>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

**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 William B White

Licensed Embalmer No. 4291

P. O. Address 4228 Bevington

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