

XC-351 521

SL 10306

7796

STATE FILE NUMBER

ENDED

Registration District No. **318**  
 FILED VS AUG 17 1960

Primary Registration District No. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N. GRAND, ST. LOUIS, MO.</b>		Length of stay in 1b <b>10 days</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>VET. ADM. HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3800 FAIRVIEW</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>ROY</b>	First <b>ROY</b>	Middle <b>J.</b>	Last <b>SCHAEFFER</b>	4. DATE OF DEATH Month <b>AUGUST</b> Day <b>6</b> Year <b>1960</b>
5. SEX <b>MALE</b>	6. COLOR OR 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>8/12/91</b>	9. AGE (last birthday) <b>68</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>METER READER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>KANSAS CITY, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>ELMER SCHAEFFER</b>		13b. MOTHER'S MAIDEN NAME <b>KATE HACKETT</b>		14. NAME OF HUSBAND OR WIFE <b>HELEN SCHAEFFER</b>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-1</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>Helen Schaeffer, 3800 Fairview, St. Louis, Mo.</b>	Address
---	--	--	---------

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>RESPIRATORY FAILURE</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>MARKED PULMONARY EMPHYSEMA</b>		
DUE TO (c) <b>527.1</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>EMACIATION SECONDARY TO PULMONARY EMPHYSEMA</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 **7/27/60** to **8/6/60** and last saw him alive on **8/6/60**  
 Death occurred at **3:40 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Robert A. Honata, M.D.</i>	(Degree or title) <b>D.M.D.</b>	22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>8/6/60</b>
---	------------------------------------	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>AUG. 8 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>
---	---------------------------------	---	--

24. FEDERAL DIRECTOR <i>Thomas Kute 2906 Greer</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>AUG 8 1960</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Elena Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grav

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.