

ENDED

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>St. Louis</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Length of stay in lb <b>2 Years</b>		c. CITY OR TOWN <b>Pasadena Hills</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>Bethesda Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>7228 Roland Blvd</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>NMN</b> Last <b>Dischinger</b>				4. DATE OF DEATH Month <b>October</b> Day <b>20</b> Year <b>1960</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1/5/1873</b>		9. AGE (last birthday) <b>87</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A. (Nat)</b>		
13a. FATHER'S NAME <b>Schatz</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Carl F. Dischinger</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>None</b>		17. INFORMANT Address <b>Mrs Carl H. Mueller 7228 Roland Blvd</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>Cerebral Hemorrhage, etc.</b> DUE TO (b) <b>Arteriosclerotic Vascular disease etc.</b> DUE TO (c) <b>331X</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>NO DA</b>		
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			
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 <b>5 A</b> 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 <b>St. Louis Co, Missouri</b>		STATE	
21. I attended the deceased from <b>June 1958</b> to <b>Oct 26 1960</b> and last saw her/him alive on <b>Oct 19 1960</b> Death occurred at <b>5 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Dr. Osabough M.D.</b>				22b. ADDRESS <b>Webster Groves Mo.</b>				22c. DATE SIGNED <b>10/21/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/22/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis Co, Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar Blvd</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 21 1960</b>		26. REGISTRAR'S SIGNATURE <b>Neal Smith, M.D.</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. O.D. Seabaugh

105 W. Lockwood

Wo. 1-5002

3 to 5 P.M.

1917

APR 10 1917

APR 10 1917

APR 10 1917

APR 10 1917

1917, 1918

1917, 1918

1917, 1918

1917, 1918

1917, 1918

1917, 1918

1917, 1918

1917, 1918

1917, 1918

(1917)...

1917, 1918

1917, 1918

1917, 1918

1917, 1918

1917, 1918

1917, 1918

1917, 1918

1917, 1918

1917, 1918

1917, 1918

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

*Jos. E. McCulloch*

Licensed Embalmer No. 2768

P. O. Address 6170 Ill.

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.