

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 9 Days	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Little Rock Hospital, Inc.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6148 Alaska Ave.
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First George Middle Phillip Last Scholl	4. DATE OF DEATH Month November Day 4 Year 1960
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-27-1879	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pensr. Ass't Cashier	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Christine Blosser	14. NAME OF HUSBAND OR WIFE Pauline L. Scholl
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. George H. Scholl, Statler	Address 5616
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding from Esophageal Ulcer DUE TO (b) Pyelonephritis acute and Chronic DUE TO (c) Uremia 539-1	INTERVAL BETWEEN ONSET AND DEATH
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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 type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from Oct. 26, 1960 to Nov. 4, 1960 and last saw him alive on Nov. 4, 1960  
Death occurred at 12:40 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>George H. Scholl</i> (Degree or title) M.D.	22b. ADDRESS 1755 S. Grand Blvd.	22c. DATE SIGNED 11-5-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 11/7/60	23c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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24. FUNERAL DIRECTOR Drehmann-Harral Funeral Home St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. NOV 7 1960	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
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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 Warren A. Carr

Licensed Embalmer No. 353

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

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.