

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-049116

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3745 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1963			
<p>1. PLACE OF DEATH</p> <p>a. COUNTY St. Louis</p> <p>b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Normandy Length of stay in 1b 8 Days</p> <p>c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Charles 1st. Nursing Home Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE Missouri b. COUNTY St. Louis</p> <p>c. CITY OR TOWN Ferguson, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) 222 Carson Road Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>		
<p>3. NAME OF DECEASED First Middle Last EMILIE ANNA SCHRIEFER</p>			
<p>4. DATE OF DEATH Month Day Year December 19, 1962</p>			
<p>5. SEX Female</p>	<p>6. COLOR OR RACE White</p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 4-29-1884</p>
<p>9. AGE (last birthday) 78</p>		<p>IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY Own Home</p>	
<p>11. BIRTHPLACE (City and state or country) St. Louis, Missouri</p>		<p>12. CITIZEN OF WHAT COUNTRY U.S.A.</p>	
<p>13a. FATHER'S NAME Henry Lochmoeller</p>		<p>13b. MOTHER'S MAIDEN NAME Anna Heinemann</p>	
<p>14. NAME OF HUSBAND OR WIFE William E. Schriefer(dec)</p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None</p>	
<p>16. SOCIAL SECURITY NO. None</p>		<p>17. INFORMANT Mrs. Emily Arkes, 4580 Washington Florissant, Mo.</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Cerebrovascular accident</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic cardio-vascular disease</p> <p>DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____</p>			<p>INTERVAL BETWEEN ONSET AND DEATH 6 1/2 weeks</p> <p>indefinite</p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____</p>			
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year _____</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>		<p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p>	
<p>21. I attended the deceased from February 13, 1959 to December 19, 1962 and last saw her alive on December 14, 1962</p> <p>Death occurred at 10:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p>22a. SIGNATURE (Degree or title) <i>Harold A. Herbeck, MD</i></p>		<p>22b. ADDRESS Toothland Medical Bldg. (36)</p>	
<p>22c. DATE SIGNED 12-21-62</p>		<p>22d. SIGNATURE <i>John B. Murphy, M.D.</i></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE Dec. 22, 1962</p>	
<p>23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery</p>		<p>23d. LOCATION (City, town, or county) St. Louis County, Missouri</p>	
<p>24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Natural Bridge Bl.</p>		<p>25. DATE RECD. BY LOCAL REG. 12-21-62</p>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

Dr. G. Russell Aufderheide
Northland Medical Bldg.
EV 3-6818

HOURS: ~~Monday - 11 AM - 3 PM~~
FRIDAY 1-5

COUNTY

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed *Robert E. Matheman*

Licensed Embalmer No. 4916

P. O. Address *St. Louis, Mo.*

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