

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32188**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8227**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(c) Name of hospital or institution **City Sanitarium**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **59 months** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **County**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **3639 Commonwealth Maplewood**
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **EMMA SCHIPPERS**
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **21** year **1946** hour **9:30** minute **A.** M.
21. I hereby certify that I attended the deceased from **Febr 2nd**, 1946, to **Sept., 21,** 1946; that I last saw h. **er** alive on **Sept., 21,** 1946; and that death occurred on the date and hour stated above.

4. Sex **female** / 5. Color or race **white**
6. (a) Single, widowed, married, divorced **separated**
6. (b) Name of husband or wife **W.M.** 6. (c) Age of husband or wife if alive **61** years
7. Birth date of deceased **July 28 1887** (Month) (Day) (Year)

Immediate cause of death **Cerebral Hemorrhage- left Parietal** Duration **1 week.**

8. AGE: Years **59** Months **1** Days **23** If less than one day hr. min.

~~xxx~~ Hypertrophy and Dilatation of the Heart **1 yr x**

9. Birthplace **St. Louis Missouri** (City, town, or county) (State or foreign country)
10. Usual occupation **Housework**

Due to **95**
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy **Yes**

11. Industry or business
12. Name **Michael Queenan**
13. Birthplace **Boston Mass.** (City, town, or county) (State or foreign country)
14. Maiden name **Louise Bile**
15. Birthplace **St. Louis Missouri** (City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Helena A. Trichter**
(b) Address **5400 Arsenal St**
17. (a) **BURIAL** (b) Date thereof **9-26-46** (Month) (Day) (Year)
(c) Place: burial or cremation **CALVARY**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) Means of injury **0**

18. (a) Signature of funeral director **Paulen Kelly**
(b) Address **4386 Lindell**
19. (a) **SEP 25 1946** (Date received local registrar) **J. Z. Bredeck** (Registrar's signature)

23. Signature **Jack Wideman** (M. D. or other) Address **5400 Arsenal St** Date signed **9/21/46**

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

JUN 24 1958

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Howard R Rowland

Licensed Embalmer No. 3114

P. O. Address Stennis 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 this body is not embalmed, fact should be so stated above.