

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 23 1946
318

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10906

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 4066 a MIAMI
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME JAMES SCHAEFER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18th
year 1946 hour 9:15 minute _____ P. M.

21. I hereby certify that I attended the deceased from 10/31/46
19 _____, to Dec. 18th 19 46

4. Sex MALE 5. Color or race white

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased OCT. 23 1946
(Month) (Day) (Year)

that I last saw h. im alive on Dec. 18th 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death SPINA BIFIDA, and MENINGOCELE, INFECTED

Duration Life (7 weeks)

8. AGE: Years _____ Months 1 Days 25
If less than one day _____ hr. _____ min.

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

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9. Birthplace ST. LOUIS Mo. D.
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations: _____

Of autopsy: _____

10. Usual occupation _____

11. Industry or business _____

12. Name DELLOS SCHAEFER

13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name FLORENCE KEIGHTLEY

15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant DELLOS SCHAEFER

(b) Address 4066 a MIAMI

17. (a) CREMATION (b) Date thereof DEC. 19 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation MISSOURI CREMATORY

18. (a) Signature of funeral director James A. Kinser, M.D.

(b) Address 2906 GRAVOIS

19. (a) DEC 19 1946 (b) Registrar's signature J. F. Brudeck

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? _____

(e) While at work? _____
(Specify type of place) (City or town) (County) (State)

23. Signature James A. Kinser, M.D. Date signed 12/19/46

Address 1515 Lafayette Date signed _____

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

MOTHER FATHER

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.....

Walter Embalmer

..... Licensed Embalmer No.....

..... P. O. Address.....

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.