

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10603

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>2967</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>3944 Chippewa St.,</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Anthony Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>3944 Chippewa St.,</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Emma</u>			b. (Middle) _____			c. (Last) <u>Schachner</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>3/30/49</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Jan. 10, 1889</u>	
9. AGE (In years last birthday) <u>60</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 6 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Nick Schachner</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Arberger</u>			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>95-26-5554</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Herman Schachner--1919 Withnell</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia General.</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Gangrenous Gall Bladder</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>None</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 days</u> <u>127 h</u> <u>58 h</u>	
19a. DATE OF OPERATION <u>3/23/49</u>		19b. MAJOR FINDINGS OF OPERATION <u>P.M. done by Dr. Vortwands Pathologist STANT Hosp.</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) COUNTY STATE _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>3/21</u> 19 <u>49</u> , to <u>3/30</u> , 19 <u>49</u> that I last saw the deceased alive on _____, and that death occurred at <u>10:30 P.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Wm Simpson M.D.</u> (Degree or title)				23b. ADDRESS <u>3739 Gravois</u>		23c. DATE SIGNED <u>3/31/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/2/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>SS Peter & Paul Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri.</u>	
DATE REC'D BY LOCAL REG. <u>APR 1 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Losater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wacker-Heldule 3634 Gravois Ave.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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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
Student Embalmer

Signed

Robert Wheeler

Licensed Embalmer No.

2128

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 this body is not embalmed, fact should be so stated above.