

FILED JUL 5 1949

STANDARD CERTIFICATE OF DEATH

State File No. 5365

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4757 Greer Ave.	
d. STREET ADDRESS (If rural, give location) 6 4757 Greer Ave.			

3. NAME OF DECEASED (Type or Print) a. (First) Margaret b. (Middle) C. c. (Last) Schaffer		4. DATE OF DEATH (Month) (Day) (Year) 6/19/49	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 12/14/1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 77
		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? 0

13a. FATHER'S NAME August Schaffer	13b. MOTHER'S MAIDEN NAME Bridget Flannery	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Edward Schaffer 4757 Greer Ave.		

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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyperthyroidism		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Endocarditis		
	DUE TO (c) Myocarditis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Minute)	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 Jan 1943 to June 1949, that I last saw the deceased alive on 6/19, 1949, and that death occurred at 1 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Helleon O Mowley M.D.	23b. ADDRESS 3625 Fair	23c. DATE SIGNED 6/20/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/22/49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. JUN 21 1949	REGISTRAR'S SIGNATURE J.B. Kataran	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan Funeral Dir., 2849 Euclid
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(Licensed Embalmer's Statement on Reverse Side)

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

8/31
Dr. William Mowrey
3625 Fair Ave.
NE. 5353

1-3 pm

494

Mowrey

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Robert L. Brinkman

Licensed Embalmer No. 3553

Signed.....
Student Embalmer

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.