

FILED DEC 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39257

318

1003

State File No.

10012

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ 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 <i>Mo</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis</i>		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <i>2610 Iowa Ave.</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis</i>	
		d. STREET ADDRESS (If rural, give location) <i>23 2610 Iowa Ave.</i>	
3. NAME OF DECEASED a. (First) <i>Caroline</i> (Type or Print)		b. (Middle) <i>Scheer</i>	
		c. (Last)	
4. DATE OF DEATH <i>November 19, 1949</i>		5. SEX <i>Male</i>	
6. COLOR OR RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	
8. DATE OF BIRTH <i>Jan. 17, 1882</i>		9. AGE (in years last birthday) <i>67</i>	
		IF UNDER 1 YEAR Days <i>10</i>	
		IF UNDER 24 HRS. Hours <i>2</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>St. Louis, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>John Weing</i>		13b. MOTHER'S MAIDEN NAME <i>Rosina Witt</i>	
14. NAME OF HUSBAND OR WIFE <i>Bernard Scheer</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <i>Bernard Scheer</i>		ADDRESS <i>2610 Iowa Ave.</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral Hemorrhage (apoplexy)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Arterio sclerosis</i>		<i>eyes</i>	
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
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) <i>97</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>113-31X</i>			
22. I hereby certify that I attended the deceased from <i>April 20, 1949</i> , to <i>Nov 19, 1949</i> , that I last saw the deceased alive on <i>Nov. 19, 1949</i> , and that death occurred at <i>5:45 P. m.</i> , from the causes and on the date stated above.			
23a. SIGNATURE <i>B. J. Mc Ferris M.D.</i> (Degree or title)		23b. ADDRESS <i>16 Hampton Village Plaza</i>	
		23c. DATE SIGNED <i>11/19/49</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>Nov. 23, 1949</i>	
24c. NAME OF CEMETERY OR CREMATORY <i>Resurrection Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i>	
DATE REC'D BY LOCAL REG. <i>NOV 21 1949</i>		REGISTRAR'S SIGNATURE <i>J. B. Sauter</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Gebken Sons</i>		ADDRESS <i>2630 Gravois Ave.</i>	

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

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.

Signed..... *Robert F. Geffner*

Signed.....
Student Embalmer

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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.