

FILED JAN 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
318 1003

State File No. 42926
11310
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. 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) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	
c. LENGTH OF STAY (In this place) 30 YRS		d. STREET ADDRESS (If rural, give location) 2935a CAROLINE STREET	
d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL			

3. NAME OF DECEASED a. (First) DORAN b. (Middle) M. c. (Last) SCHAEFER		4. DATE OF DEATH (Month) (Day) (Year) 12 31 - 49	
---	--	--	--

5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH NOVEMBER 19, 1900	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months 1	IF UNDER 1 YEAR Days 11	IF UNDER 1 HRS. Hours Min.
-------------	-----------------------	---	---------------------------------------	---------------------------------------	--------------------------------	-------------------------------	----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? D
--	--	---	-----------------------------------

13a. FATHER'S NAME HENRY SKAGGS	13b. MOTHER'S MAIDEN NAME SARAH GELAM	14. NAME OF HUSBAND OR WIFE JOHN J.
------------------------------------	--	--

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 DELORES HOBUSCH	ADDRESS 4322a W. PAPIN 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) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH
	2. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	3. 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 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) St. Louis MO
--	--	---

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? Fall
---	--	------------------------------------

22. I hereby certify that I attended the deceased from Dec 26, 1949, to Dec 31, 1949, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE R. Bag M.D.	(Degree or title) V	23b. ADDRESS 3203 S Grand	23c. DATE SIGNED 12/31/49
-------------------------------	---------------------	------------------------------	------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-3-50	24c. NAME OF CEMETERY OR CREMATORY NEW PICKERS	24d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI
---	---------------------	---	--

DATE REC'D BY LOCAL REG. JAN 3 1950	REGISTRAR'S SIGNATURE J. P. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE A. H. McLaughlin	ADDRESS 2301 Dohertyville
--	--	--	------------------------------

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

11340

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

C. W. Cooper

Licensed Embalmer No. *3831*

P. O. Address *231 Sagoyette*

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.