

FILED JAN 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2991

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **164**

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 MO	c. LENGTH OF STAY (in this place) 1 DAY	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		d. STREET ADDRESS (If rural, give location) 5711 WALSH	

3. NAME OF DECEASED (Type or Print) a. (First) HENRY b. (Middle) J. c. (Last) SCHEFFEL	4. DATE OF DEATH (Month) (Day) (Year) JAN. 5 1950
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DEC. 16 1912	9. AGE (In years last birthday) 37 if UNDER 1 YEAR Months 3 Days 20 if UNDER 24 HRS. Hours 20 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCCER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST. LOUIS, MO U.S.A.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME JOHN SCHEFFEL	13b. MOTHER'S MAIDEN NAME MARGARET KIEFER	14. NAME OF HUSBAND, OR WIFE SUE SCHEFFEL
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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 SUE SCHEFFEL 5711 WALSH
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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) Rupture of aorta, cardiac end ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Dissecting aneurysm ascending & descending aorta DUE TO (c) Cardiac tamponade II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cyst, left kidney		INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) 451X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **11/2**, 19**50**, to **1/5**, 19**50**, that I last saw the deceased alive on **1/5**, 19**50**, and that death occurred at **11:20** a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thos Coates M.D.	23b. ADDRESS 5203 Chippewa	23c. DATE SIGNED 1/6/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JAN. 9, 1950	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REG. JAN 7 1950	REGISTRAR'S SIGNATURE J.B. Lassiter	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kuttig 2906 Beavert
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Handwritten mark

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 *James C. Bell*

Licensed Embalmer No. *4347*

P. O. Address *2466 Davis*

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.