

THE DIVISION OF HEALTH OF MISSOURI
FILED JUL 22 1950 STANDARD CERTIFICATE OF DEATH

State File No. **25246**
 Registrar's No. **6045**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 25246		Registrar's No. 6045	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Francois					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bismarck		1940			
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Pac. Hosp.				d. STREET ADDRESS (If rural, give location) 1					
3. NAME OF DECEASED (Type or Print)		a. (First) Julius		b. (Middle) -		c. (Last) Scheihing		4. DATE OF DEATH (Month) (Day) (Year) 7 13 50	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 10, 1886		9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE Alice			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Alice Scheihing, Bismarck, Mo.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH	
<p><i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i></p>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenoca. of prostate							10 mo.	
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) c wide spread metastasis								
	DUE TO (c)								
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)					
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? 177X					
22. I hereby certify that I attended the deceased from June 1, 1950 to July 13, 1950 , that I last saw the deceased alive on July 13, 1950 , and that death occurred at 2:55 p.m. , from the causes and on the date stated above.									
23a. SIGNATURE Robert A. Hiepkotter M.D.				23b. ADDRESS 1755 So. Grand		23c. DATE SIGNED 7-13-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-13-50	24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Bismarck, Mo.				
DATE REC'D BY LOCAL REG. JUL 13 1950		REGISTRAR'S SIGNATURE J. B. Jasater			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.				

(Licensed Embalmer's Statement on Reverse Side)

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

DEC 15 1953

AUG 21 1957

JUL 26 1950

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 M Murray

Signed.....
Student Embalmer

Licensed Embalmer No. *37491*

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.