

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26585

State File No.

FILED AUG 12 1952

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>541</u>		Registrar's No. <u>2061</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Clayton</u>		c. LENGTH OF STAY (In this place) <u>10 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Lemay 23</u>		TOWN <u>23</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Hawkins Rd. Rt. 8 Box 415</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Virginia</u> b. (Middle) <u>M.</u> c. (Last) <u>Schremp</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>8 1 52</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>14 August 1891</u>	
9. AGE (In years last birthday) <u>60</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Genevieve, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Felix Bayatte</u>			13b. MOTHER'S MAIDEN NAME <u>Susan LaPlante</u>		14. NAME OF HUSBAND OR WIFE <u>Joseph Schremp</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Joseph Schremp</u>			ADDRESS <u>Rt. 8 Box 415 Lemay, Mo.</u>
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>sarcoma of right ovary</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ <u>175X</u> DUE TO (c) _____					MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>7-30-52</u>		19b. MAJOR FINDINGS OF OPERATION <u>inoperable sarcoma of right ovary</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>		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) <u>8-1-52</u>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
I hereby certify that I attended the deceased from <u>7-22, 1952</u> to <u>8-1, 1952</u> that I last saw the deceased alive on <u>8-1, 1952</u> and that death occurred at <u>2:30 A. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Emilio W. Huber M.D.</u>				23b. ADDRESS <u>601 S. Brentwood Clayton</u>		23c. DATE SIGNED <u>8-2-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>4 Aug 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetary</u>		24d. LOCATION (City, town or county) (State) <u>1215 Lemay Ferry Rd., Lemay, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8/2/52</u>		REGISTRAR'S SIGNATURE <u>Herbert D. Donke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. Hoffmeister</u>			
				ADDRESS <u>U. & L. Co. 7814 S. Broadway</u>			

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.

Student
Student Embalmer

Signed Lina C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address. 7814 S. Broadway

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.