

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30018**  
Registrar's No. **7958**

**318**

**1003**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>St. Louis Mo (City)</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>2139</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis Mo. 2</u>		c. LENGTH OF STAY (in this place) <u>2</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>13 5400 Arsenal St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>				3. NAME OF DECEASED (Type or Print) a. (First) <u>LAURA</u> b. (Middle) <u>--</u> c. (Last) <u>SCHWARZKOPF</u>			
4. DATE OF DEATH (Month) (Day) (Year) <u>8 20 1952</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>	
8. DATE OF BIRTH <u>Apr. 17th, 1865</u>		9. AGE (in years - last birthday) <u>87 yrs</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (City and State or Foreign Country) <u>Callaway Co., Mo.</u>				12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME <u>Elise Pickering</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Maud Haberstroh</u> ADDRESS <u>7224 Teal Ave.</u>			
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) <u>Cardiac failure (acute)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>senility; arteriosclerosis</u> 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) _____			
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? <u>4500</u>			
22. I hereby certify that I attended the deceased from <u>8-1-52</u> , 19 <u>52</u> , to <u>8-20-52</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>8-20-52</u> , 19 <u>52</u> , and that death occurred at <u>10:50 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Alfonso Corp M.D.</u> (Degree or title)				23b. ADDRESS <u>5400 Arsenal St.</u>		23c. DATE SIGNED <u>8-20-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 23, 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
DATE RECD BY LOCAL REGISTRAR'S SIGNATURE <u>AUG 22 1952</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Quinn</u>		ADDRESS <u>1389 Union Blvd</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 *Bernard Hoffman*

Licensed Embalmer No. 4366

P. O. Address *Hoffman, M*

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.