

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10672**

BIRTH NO. **FILED APR 7 1954** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **547** Registrar's No. **675**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY OR TOWN <b>Richmond Heights</b>		c. CITY OR TOWN <b>Olivette</b>	
c. LENGTH OF STAY (in this place) <b>3 weeks</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Marys Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>9447-Olive Street Road</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Florentine</b> b. (Middle) <b>Maria</b> c. (Last) <b>Scheer</b>			4. DATE OF DEATH <b>March 14, 1954</b> (Month) (Day) (Year)		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 3, 1905</b>	9. AGE (In years last birthday) <b>48</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 6 HRS. Hours	12. IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Wurtwort, Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
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13a. FATHER'S NAME <b>Frederick Brockmann</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Albrecht</b>		14. NAME OF HUSBAND OR WIFE <b>Albert H. Scheer</b>			
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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) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Albert H. Scheer</b> ADDRESS <b>9447-Olive St. Rd-Clayton</b>			
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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 <b>Massive cerebral hemorrhage</b> <b>Due to (b) Hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
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? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <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)	
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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	
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22. I hereby certify that I attended the deceased from **Oct 10, 1937**, to **3/14, 1954**, that I last saw the deceased alive on **3/14-11, 1954**, and that death occurred at **6:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>S. R. Proffers MD</b> (Degree or title)		23b. ADDRESS <b>1142 Central</b>		23c. DATE SIGNED <b>8/16/54</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>3-17-1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Lutheran Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Olivette, Mo.</b>	
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DATE REC'D BY LOCAL REG. <b>3-17-54</b>		REGISTRAR'S SIGNATURE <b>Herbert R. Donke MD</b>		25. GENERAL DIRECTOR'S SIGNATURE <b>William W. Ross, Jr.</b>		ADDRESS <b>2504-Woodson Rd-Overland-14-Mo.</b>	
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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.....  
Signature of Student Embalmer

Signed *David C. Gilman*.....

Licensed Embalmer No. *34567*.....

P. O. Address *Portland*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.