

FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14059
Registrar's No. 3492

BIRTH NO. 26766-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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		c. LENGTH OF STAY (in this place) 9 days		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) Michael Schira			4. DATE OF DEATH (Month) (Day) (Year) April 18, 1954		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH April 9, 1954	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Edward Schira		13b. MOTHER'S MAIDEN NAME Mabel Stith		14. NAME OF HUSBAND OR WIFE None	
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. None		17. INFORMANT'S SIGNATURE OR NAME Edward Schira - 6248 Famous Ave.	
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) Meningitis. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) congenital spina bifida. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 48 hours 8 days
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION none			20. AUTOPSY? YES <input 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) 751X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	
22. I hereby certify that I attended the deceased from April 9, 1954, to April 18, 1954, that I last saw the deceased alive on April 17, 1954, and that death occurred at 6:00P m., from the causes and on the date stated above.					
23a. SIGNATURE John G. Kellett MD.		23b. ADDRESS - 2627 Telegraph		23c. DATE SIGNED 4/19/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Apr. 19, 1954		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	
24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith MD Hacker - Helber			
DATE REC'D BY LOCAL REG. APR 19 1954		REGISTRAR'S SIGNATURE		ADDRESS 3634 Gravois Ave.	

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

He Embalmer

Signed.....

Frank J. Gland &
Licensed Embalmer No. *26*
P. O. Address *SV Senior*

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.