

FILED JUN 8 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17458

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 1157

1. PLACE OF DEATH a. COUNTY St. Louis,		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri. b. COUNTY S. Louis	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Richmond Heights.		c. CITY OR TOWN Richmond Heights.	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (If this place) 1 DAY		e. STREET ADDRESS (If rural, give location) #4 York Hill Drive.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Marys Hospital.			

3. NAME OF DECEASED (Type or Print)	a. (First) CARL	b. (Middle) JOSEPH	c. (Last) SCHAAF.	4. DATE OF DEATH (Month) (Day) (Year) May 17, 1954.
-------------------------------------	-----------------	--------------------	-------------------	---

5. SEX Male.	6. COLOR OR RACE white.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married.	8. DATE OF BIRTH Sep't 17, 1892.	9. AGE (In years last birthday) 61.	10. UNDER 1 YEAR Months	11. UNDER 1 YEAR Days	12. UNDER 1 HRS. Hours	13. UNDER 1 HRS. Min.
--------------	-------------------------	---	----------------------------------	-------------------------------------	-------------------------	-----------------------	------------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dist Mngr Metropolitan	10b. KIND OF BUSINESS OR INDUSTRY Life Ins. Co.,	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	-------------------------------------

13a. FATHER'S NAME Paul Schaaf.	13b. MOTHER'S MAIDEN NAME Mary Dondeville.	14. NAME OF HUSBAND OR WIFE Hildegard E. Schaaf.
---------------------------------	--	--

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. 494-07-6657	17. INFORMANT'S SIGNATURE OR NAME Mrs C. J. Schaaf, #4 York Hill Dr.,	ADDRESS
--	-------------------------------------	---	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <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>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>7 yrs</i> <i>2 yrs +</i>
	ANTECEDENT CAUSES <i>Hypertension</i> <i>Thromboembolism</i> DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		

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?
---	--	----------------------------

22. I hereby certify that I attended the deceased from June 19, 1945, to May 18, 1954, that I last saw the deceased alive on 5/16, 1954, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE C. Kleinschmidt (Degree or title) M.D.	23b. ADDRESS 508 N. Grand St. St. Louis, Mo.	23c. DATE SIGNED 5/17/54
---	--	--------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Entombment.	24b. DATE 5/19/54.	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum.	24d. LOCATION (City, town, or county) (State) #7800 St. Charles Rock Road.
---	--------------------	---	--

DATE REC'D BY LOCAL REG. 5-18-54	REGISTRAR'S SIGNATURE Herbert R. Donde M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons, #7233 Delmar Blv'd.
----------------------------------	---	---

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

Carl J. Schauf. Dec'd.

W 3

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 Clarence H. Murray

Licensed Embalmer No. 4011

P. O. Address St. Louis

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.