

FILED FEB 28 1955

STANDARD CERTIFICATE OF DEATH

State File No. **5899**

BIRTH NO. _____ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058** Registrar's No. **579**

1. PLACE OF DEATH a. COUNTY ST. CHARLES			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY ST. CHARLES		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. CHARLES		c. LENGTH OF STAY (in this place) 4 DAYS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN O'FALLOON		0920
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH HOSPITAL			d. STREET ADDRESS (If rural, give location) /		

3. NAME OF DECEASED a. (First) LOUIS b. (Middle) J. c. (Last) SCHAEFFER			4. DATE OF DEATH (Month) (Day) (Year) FEB 18-1955		
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 2	8. DATE OF BIRTH SEPT. 20 1875		9. AGE (In years last birthday) 79	IF UNDER 1 YEAR 4	IF UNDER 1 MONTH 28	IF UNDER 1 HOUR 	IF UNDER 1 MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (State or foreign country) ST. CHARLES Co. Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME JACOB SCHAEFFER		13b. MOTHER'S MAIDEN NAME SALI		14. NAME OF HUSBAND OR WIFE SOPHIA SCHAEFFER DCS	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME CARL SCHAEFFER		ADDRESS R 9 ST LOUIS Co.	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphosarcoma generalized					INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 2001						

19a. DATE OF OPERATION 9/2/53	19b. MAJOR FINDINGS OF OPERATION Enlarged lymph nodes - Burry - Lymphosarcoma					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 **9-1**, 19**53**, to **2-18**, 19**55**, that I last saw the deceased alive on **2-18**, 19**55**, and that death occurred at **5:00 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Russell Glider M.D.		23b. ADDRESS St Charles Mo		23c. DATE SIGNED 2-21-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Reburial	24b. DATE 2-22-55	24c. NAME OF CEMETERY OR CREMATORY ASSUMPTION	24d. LOCATION (City, town, or county) (State) O'FALLOON Mo
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DATE REC'D BY LOCAL REG. Feb 23 1955	REGISTRAR'S SIGNATURE 284 Francis Hamel		25. FUNERAL DIRECTOR'S SIGNATURE Earl Kettig		ADDRESS O'Fallon Mo	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAN 13 1958

JUN 14 1958

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 *E. A. Keating*

Licensed Embalmer No. *822*

P. O. Address *Fallon 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.