

FILED MAR 4 1955

STANDARD CERTIFICATE OF DEATH

State File No. 6472

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 12771

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ALEXIAN BROS HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MO b. COUNTY ST. LOUIS
c. CITY OR TOWN LEMAY 4869
d. Is Residence within limits of a city or incorporated town? Yes No
e. STREET ADDRESS (If rural, give location) 2029 TELEGRAPH RD

3. NAME OF DECEASED
a. (First) FERDINAND b. (Middle) SCHACHLE c. (Last)

4. DATE OF DEATH (Month) (Day) (Year)
Feb. 9 1955

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH SEPT 26 1886

9. AGE (In years last birthday) 68

IF UNDER 1 YEAR Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. MAIL CLERK

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) OHIO

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME STEPHAN SCHACHLE

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Cecelia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Cecelia Schachle 2029 Telegraph Rd

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) Coronary Occlusion
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio Sclerotic C.V.R. Disease 10
DUE TO (c) Rheumatic Heart Disease 10
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES NO

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) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 4201

22. I hereby certify that I attended the deceased from Jan 1954, to Feb 9, 1955, that I last saw the deceased alive on Feb 8, 1955, and that death occurred at 3:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE C. A. Nester MD (Degree or title)

23b. ADDRESS 5600 S. Compton

23c. DATE SIGNED 2-10-55

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

24b. DATE 2-12-1955

24c. NAME OF CEMETERY OR CREMATORY RESURRECTION

24d. LOCATION (City, town, or county) (State) ST. LOUIS CO MO

DATE REC'D BY LOCAL REG. FEB 11 1955

REGISTRAR'S SIGNATURE Carl Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JOS. P. FENDLER JR 7128 Michigan

WRITE PLAINLY—USING UNFAADING 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 emb

by me, or by Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Clarence Johnson*.....

Licensed Embalmer No. *309*

P. O. Address *7128 Michigan*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.