

FILED JUN 9 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16969
Registrator's No. 4306

BIRTH NO. _____ 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) St. Louis		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) Life		e. STREET ADDRESS 13 5400 Arsenal Street		2130	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital					

3. NAME OF DECEASED (Type or Print) Rudolph Schaar			4. DATE OF DEATH (Month) (Day) (Year) May 11, 1955		
a. (First)		b. (Middle)	c. (Last)		

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Feb. 16, 1878	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 12 HRS. Hours	IF UNDER 12 HRS. Min.
----------------	---------------------------	--	-----------------------------------	---------------------------------------	---------------------------	--------------------------	---------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FACTORY WORKER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) ST LOUIS MO 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	---	--

13a. FATHER'S NAME Frank	13b. MOTHER'S MAIDEN NAME Caroline Schlanker	14. NAME OF HUSBAND OR WIFE
-----------------------------	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Donald Baker	ADDRESS 2331 W. Mullinphy
---	------------------------------------	---	------------------------------

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lobar pneumonia, right middle and lower and left upper lobe</u>		10 days
	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 <u>Sarcoma, left chest wall extending to</u>			1 yr?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION left pleura and lung	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)
--	--	---

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? H9DX
---	--	------------------------------------

22. I hereby certify that I attended the deceased from 7-1-52, 19____, to 5-11____, 1955, that I last saw the deceased alive on 5-11____, 1955, and that death occurred at 6:25p m., from the causes and on the date stated above.

23a. SIGNATURE Clement Hyman M.D.	(Degree or title) M.D.	23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 5-13-55
--------------------------------------	---------------------------	----------------------------------	-----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAY-17-55	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) ST LOUIS MO
---	------------------------	---	--

DATE REC'D BY LOCAL REG. MAY 16 1955	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Cullen Kelly	ADDRESS 4386 Lindell
---	---	--	-------------------------

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

S.P. (Licensed Embalmer's Statement on Reverse Side)

SEP 3 1957

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..... *Gene A. Hutchens*

Licensed Embalmer No..... *496*

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.