

FILED MAY 25 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17030

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3992**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (In this place) <b>Life</b>	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3627 Holt Ave.</b>		STREET ADDRESS (If rural, give location) <b>3627 Holt Ave.</b>	

3. NAME OF DECEASED (Type or Print) <b>Clara</b>	a. (First)	b. (Middle)	c. (Last) <b>Stahlschmidt</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>May 4, 1955</b>
--	------------	-------------	-------------------------------	--

5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>W.</b>	8. DATE OF BIRTH <b>Nov. 25, 1862</b>	9. AGE (In years last birthday) <b>92</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>9</b>	IF UNDER 24 HRS. Hours Min.
------------------	----------------------------	--	---------------------------------------	---	---	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Peters, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
--	-----------------------------------	---	--

13a. FATHER'S NAME <b>Unk. Willott</b>	13b. MOTHER'S MAIDEN NAME <b>Unk. Unk.</b>	14. NAME OF HUSBAND OR WIFE <b>Frank Stahlschmidt</b>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Miss Viola Stahlschmidt, 3627 Holt Ave.</b>
--	-------------------------------------	--

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, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Starvation Acidosis</b>		<b>?</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Generalized Abdominal Malig-nancy</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>1991</b>
--	--	--

22. I hereby certify that I attended the deceased from **Mar 21**, 19**55**, to **May 4**, 19**55**, that I last saw the deceased alive on **5/4**, 19**55**, and that death occurred at **9:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. P. Makadu M.D.</b>	(Degree or title)	23b. ADDRESS <b>Humboldt Bldg.</b>	23c. DATE SIGNED <b>5/4/55</b>
---	-------------------	------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>May 7, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Francis Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Portage De Sioux, Mo.</b>
---	------------------------------	--	--

DATE REC'D BY LOCAL REG. <b>MAY 5 1955</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>3840 Lindell Blvd.</b>
--	---	--

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

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 me....., Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed [Handwritten Signature].....

Licensed Embalmer No. 46

P. O. Address 3840

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.