

FILED SEP 9 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28126

State File No.

318

REG. DIST. NO. PRIMARY REG. DIST. NO. 1003

6661

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 6661	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis,		c. LENGTH OF STAY (In this place) 5 days		c. CITY OR TOWN Lemay		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Anthonys Hospital				STREET ADDRESS (If rural, give location) 620 Allen Ave.			
3. NAME OF DECEASED (Type or Print) HERMAN		a. (First)		b. (Middle) A.		c. (Last) SCHARPER	
4. DATE OF DEATH July 30, 1955		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Nov. 4, 1907		9. AGE (In years last birthday) 47		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Sam'l Krause Const		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Herman Scharper		13b. MOTHER'S MAIDEN NAME Louisia Mehler		14. NAME OF HUSBAND OR WIFE Minnie Scharper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 489-16-7187		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Minnie Scharper, 620 Allen Ave.			
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bowel obstruction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) metastatic carcinoma of bowel DUE TO (c) Primary carcinoma of sigmoid. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 wk. 6 mos 1 yr.	
19a. DATE OF OPERATION Feb. 55		19b. MAJOR FINDINGS OF OPERATION as above.				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) 153X			
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 6/1, 1954 , to 7/30, 1955 , that I last saw the deceased alive on 7/30, 1955 , and that death occurred at 11:30A. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) George A. O'Sullivan, M.D.				23b. ADDRESS 21 N. Schermer, St. Louis Mo		23c. DATE SIGNED 8-1-55	
24a. BURIAL CREMATION (Specify) Burial		24b. DATE 8/2/1955		24c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery		24d. LOCATION (City, town, or county) (State) Lemay 23, Mo.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 2 1955		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fendler Und. Co. 7420 Michigan Ave.			

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

Dr. G. O. Sullivan

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 *W. G. Peterson*

Licensed Embalmer No. *37*

P. O. Address *7420 Main*

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.