

FILED SEP 1 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28127
State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6707**

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

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. LENGTH OF STAY (in this place) 2 YRS	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters of the Poor		f. STREET ADDRESS (If rural, give location) 3400 S. Grand Blvd.	
3. NAME OF DECEASED (Type or Print) Rose		a. (First)	b. (Middle)
		c. (Last) Schirmer	4. DATE OF DEATH (Month) (Day) (Year) August 1, 1955
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH November 13, 1872
9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Month 8 Days 17	IF UNDER 24 HRS. Hours 17 Min.	11. BIRTHPLACE (City and State or Foreign Country) Not known
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Philip Mundy		13b. MOTHER'S MAIDEN NAME Rose Byrnes	14. NAME OF HUSBAND OR WIFE Henry
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sister Henry 3400 S. Grand Blvd.	
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) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General Arteriosclerosis 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"/>	INTERVAL BETWEEN ONSET AND DEATH yes yes
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) St. Louis, Mo	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		4200
22. I hereby certify that I attended the deceased from Jan 1955 , to 8/1/55 , 19___, that I last saw the deceased alive on 8/30/55 , 19___, and that death occurred at 5:30 P m., from the causes and on the date stated above.			
23a. SIGNATURE R. A. Mezera M.D.		23b. ADDRESS 539 NO. GRAND	23c. DATE SIGNED 8/1/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/3/55	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. CITY, TOWN OR TOWNSHIP (City, town or county) (State) St. Louis, MO.
DATE REC'D BY LOCAL REG. AUG 2 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Gebken Sons 2630 Gravois Ave,	

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 *Robert F. Gebhardt*

Licensed Embalmer No. *415*

P. O. Address *2630 Gravois*

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.