

FILED OCT 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31463

8444

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give town(ship) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>30 days</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>4210 W. Sacramento Ave.</u> <u>10</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Maude</u> b. (Middle) <u>Belle</u> c. (Last) <u>Schroeder</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9 - 25 - 1955</u>					
5. SEX <u>Fem</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>9 - 15 - 1900</u>		
9. AGE (In years last birthday) <u>55</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Clayton, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Peter Schaeffer</u>			13b. MOTHER'S MAIDEN NAME <u>Belle Carmen</u>		14. NAME OF HUSBAND OR WIFE <u>William Schroeder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Charles Keller, 1955 Driftway Ave</u>				
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain Tumor -</u> 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>193x</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>
19a. DATE OF OPERATION <u>9/13/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Malignant Brain Tumor - Spargerblastoma</u>				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? _____				
22. I hereby certify that I attended the deceased from <u>9/11</u> , 19 <u>55</u> , to <u>9/25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/24</u> , 19 <u>55</u> , and that death occurred at <u>7:30 A.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Edwina A. Smolic MD</u>				23b. ADDRESS <u>Beaumont Mrs Bldg</u>		23c. DATE SIGNED <u>9/26/55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>9/28/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>		
DATE REC'D BY LOCAL REG. <u>SEP 26 1955</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Drehmann-Harral 1905 Union Blvd.</u>				

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Albert P. Thompson*

Licensed Embalmer No. *42*

P. O. Address *Mo...*

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