

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35134**  
Registrar's No. **9292**

FILED NOV 15 1955

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>9292</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		d. STREET ADDRESS (If rural, give location) <b>1127 McCausland</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1127 McCausland</b>				d. STREET ADDRESS <b>1127 McCausland</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>JOSEPH</b>		b. (Middle) <b>FRANKLIN</b>		c. (Last) <b>SCHIERMAN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>October 24, 1955</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>April 19, 1884</b>	
9. AGE (In years last birthday) <b>71</b>		IF UNDER 1 YEAR Days <b>6</b>		IF UNDER 12 HRS. Hours <b>5</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>	
11. BIRTHPLACE (State or foreign country) <b>Carlyle, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>FRED J. SCHIERMAN</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Josie Miller Schierman</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Josie M. Schierman</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebro-vascular accident</b>		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>arteriosclerosis</b>					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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.							
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) <b>331*</b>			
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 <b>Aug 21, 1955</b> , to <b>Oct. 24, 1955</b> , that I last saw the deceased alive on <b>Oct 24, 1955</b> , and that death occurred at <b>7:45 am.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Robert M. Smith</b> (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>114 N. Taylor</b>		23c. DATE SIGNED <b>10-25-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>10/27/55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>OCT 25 1955</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ambruster Mortuary, 6633 Clayton Rd.</b>			

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

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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 .....  
Student Embalmer

Signed \_\_\_\_\_

*Fred J. Fanner*

Licensed Embalmer No. 4788

P. O. Address St. Louis Mo.

**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 this body is not embalmed, fact should be so stated above.