

FILED JAN 11 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42590  
State File No. \_\_\_\_\_  
Registrar's No. 11496

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Missouri	b. COUNTY St. Louis
c. LENGTH OF STAY (If in place) 10 days		c. CITY OR TOWN Lemay	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		e. STREET ADDRESS (If rural, give location) 3501 Lemay Ferry Road	

3. NAME OF DECEASED (Type or Print)	a. (First) JULIA	b. (Middle)	c. (Last) SCHREIBER	4. DATE OF DEATH (Month) (Day) (Year) 12-28-55
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 12-19-1893	9. AGE (In years last birthday) Months Days 62	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) Ohio	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Frank McHugh	13b. MOTHER'S MAIDEN NAME Marie Truex	14. NAME OF HUSBAND OR WIFE Henry Schrieber
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME Wm. Schrieber, 3501 Lemay Ferry	ADDRESS
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18. CAUSE OF DEATH PER line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) THROMBOSIS OF SPLENIC VEIN SECONDARY SHOCK Secondary shock		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) HYPERTENSIVE HEART DISEASE Hiatus hernia DUE TO (c) A.S. Heart disease A.S. HEART DISEASE		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 560.4	20. AUTOPSY? a. m. YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 12-26-1955, to 12-28-1955, that I last saw the deceased alive on 12-28-1955, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE Carol Popp	(Degree or title) M.D.	23b. ADDRESS St. John's Hosp.	23c. DATE SIGNED 12/29/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 12-31-55	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL DEC 30 1955	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Edw. Fendler, 5611 S. Grand ave.	ADDRESS
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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 *Ronald O Yahnke* .....

Licensed Embalmer No. *391*

P. O. Address *St. Louis*

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.