

FILED APR 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11009**
Registrar's No. **3152**

REG. DIST. NO. **318**

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

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3152	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri. b. COUNTY _____			
b. CITY OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) 16 DAYS.		c. CITY OR TOWN St. Louis,		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 St. Louis Chronic Hospital				e. STREET ADDRESS (If rural, give location) 7821 Michigan Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Agnes		b. (Middle) Marie		c. (Last) Schaab		4. DATE OF DEATH (Month) (Day) (Year) March 29-1957	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 18, 1890	
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 1 WKS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Retired housewife		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Simon			13b. MOTHER'S MAIDEN NAME Rose ?			14. NAME OF HUSBAND OR WIFE Adam Schaab.	
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. 493-20-6741		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Adam Schaab 7821 Michigan 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis DUE TO (c) Cerebral arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH 13 yrs. 13 yrs. 13 yrs. 9 yrs.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 443x		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
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 March 13, 1957 , to March 29, 1957 , that I last saw the deceased alive on March 29, 1957 , and that death occurred at 1:50 AM. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) John W. Beckham, M.D.				23b. ADDRESS 5800 Arsenal		23c. DATE SIGNED 3/29/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 4-1-57		24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
DATE REC'D BY LOCAL REG. APR 1 '57		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE. ADDRESS Fendler Und. Co. 6420 Michigan Ave.			

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.....
W. G. Peterson

Licensed Embalmer No. *3761*

P. O. Address *7420 Mich*

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.