

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15252

FILED MAY 1 - 1957

State File No. _____

2868

BIRTH NO. 26844-57 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY St. Louis

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY ST. Louis

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Web. Groves 4597

d. FULL NAME OF HOSPITAL OR INSTITUTION Evangelical Deaconess Hospital

e. STREET ADDRESS (If rural, give location) 109 N. Rock Hill Rd.

3. NAME OF DECEASED
a. (First) JON b. (Middle) ELIOT c. (Last) SCHOEPHOESTER

4. DATE OF DEATH
(Month) (Day) (Year) 3 - 24 - 57

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH 3-22-57

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 1 MRS. Hours Min. 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT

10b. KIND OF BUSINESS OR INDUSTRY NONE

11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Harold Schoephoester

13b. MOTHER'S MAIDEN NAME Hazel Oberle

14. NAME OF HUSBAND OR WIFE NONE

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. NONE

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Harold Schoephoester 109 N. Rock Hill Rd.

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, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis

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. 762.0

INTERVAL BETWEEN ONSET AND DEATH
30 hrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES 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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from 3-22 - 1957, to 3-24, 1957 that I last saw the deceased alive on 3-24 - 19 57 and that death occurred at 1:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) L. Kirtz - J. Martin MD

23b. ADDRESS 337 W. Lockwood

23c. DATE SIGNED 3-24-57

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

24b. DATE 3-26-57

24c. NAME OF CEMETERY OR CREMATORY OUR REDEEMER CEMETERY

24d. LOCATION (City, town, or county) (State) ST. Louis Co. Mo.

DATE REC'D BY LOCAL REG. MAR 25 '57

REGISTRAR'S SIGNATURE Paul Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS MITTELBERG FUNERAL HOME WEBSTER GROVES, MO.

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

m88

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.

NOT EMBALMED

Student _____
Student Embalmer

Signed _____

Chas. J. Cox

Licensed Embalmer No. _____

P. O. Address _____

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.