

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAY 27 1957

19246  
State File No. 4464  
Registrar's No.

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)  
a. STATE b. COUNTY

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis  
c. LENGTH OF STAY (If this place) 7 days

c. CITY OR TOWN St. Louis  
d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hosp.  
e. STREET ADDRESS (If rural, give location) 1570 3623 Montana

3. NAME OF DECEASED  
a. (First) Anne b. (Middle) Schachner c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) 5--8-1957

5. SEX female  
6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow

8. DATE OF BIRTH SEPT. 25, 1868  
9. AGE (In years last birthday) 88

IF UNDER 1 YEAR Months - Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work for during most of working life, even if retired) HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY AT HOME

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

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME L. Swearingin

13b. MOTHER'S MAIDEN NAME Elizabeth ?

14. NAME OF HUSBAND OR WIFE PETER A. SCHACHNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name of branch) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. NONE

17. INFORMANT'S SIGNATURE OR NAME ADDRESS FRANCES AUSTIN 3623 MONTANA

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, asphyxia, etc. It means the disease, injury, or complication which caused death.  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Coronio-sclerotic Heart Dis.  
INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mo.  
ANTECEDENT CAUSES  
Morbidity 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. 420.0

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) m.

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 5-1-57, 19\_\_, to 5-8-57, 19\_\_, that I last saw the deceased alive on 5-8-57, 19\_\_, and that death occurred at 12:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John W. Beckham, M.D.

23b. ADDRESS 5800 Arsenal St.

23c. DATE SIGNED 5/8/57

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

24b. DATE MAY 11 1957

24c. NAME OF CEMETERY OR CREMATORY New St. MARCUS

24d. LOCATION (City, town, or county) (State) ST. LOUIS MO

DATE REC'D BY LOCAL REG. MAY 10 57

REGISTRAR'S SIGNATURE [Signature]

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS [Signature] 2906 Gravois

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.....  
Licensed Embalmer No. 3988  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.