FILED MAY 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19601
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 1192

1. PLACE OF DEATH a. COUNTY St. Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis ✓
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Overland — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN Lemay 4000 — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Overland Restorium — Length of stay in 1b 2 Mon.	d. STREET ADDRESS (If outside, give location) 3547 Summit Ave. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First: ALMA	Middle: E.	Last: SCHACHNER	4. DATE OF DEATH	Month: May Day: 7 Year: 1957
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: May 8, 1886	9. AGE (In years last birthday): 70	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework	10b. KIND OF BUSINESS OR INDUSTRY: At Home	11. BIRTHPLACE (City and state or country): Lutesville, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: David Sheer		14. MOTHER'S MAIDEN NAME: Amanda Spencer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None	16. SOCIAL SECURITY NO.: 494-28-3431	17. INFORMANT: Olive M. Hudson — Address: 8983 Midland Ave. Overland, Mo.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Arteriosclerosis - heart failure	1 yr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arrhosis of liver	2 mo
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	5810	19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4-1-57, to 5-6-57 and last saw her/him alive on 5-6-57
Death occurred at 10:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): H W Noller MD	22b. ADDRESS: 3720 Washington	22c. DATE SIGNED: 5-8-57
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 10, 1957	23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Jefferson Barracks, Mo.		
24. FUNERAL DIRECTOR: Kriegshauser — ADDRESS: 4228 S. Kingshighway	25. DATE RECD. BY LOCAL REG.: 5-8-57	26. REGISTRAR'S SIGNATURE: Herbert R. Demke MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed....William B. White.....

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.