

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34106**
8862

FILED OCT-4 1957

1093

BIRTH NO. _____		REG. DIST. 318		PRIMARY REG. DIST. _____		Registrar's No. _____	
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, Missouri.		c. LENGTH OF STAY (In this place) 3 Mo 29 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) 1910 4360 Olive			
3. NAME OF DECEASED (Type or Print) a. (First) Mary			b. (Middle) R		c. (Last) Schoenefeld		4. DATE OF DEATH (Month) (Day) (Year) September 21--1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 1 1872		9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Louis Rose			13b. MOTHER'S MAIDEN NAME Rosiana Malardt		14. NAME OF HUSBAND OR WIFE Karl - Died in 1913		
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 Karl Schoenefeld Grover Mo			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) INFARCTION OF MYOCARDIUM ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO ARTERIOSCLEROTIC DUE TO (c) HEART DISEASE II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death ARTERIOSCLEROTIC HEART DISEASE					INTERVAL BETWEEN ONSET AND DEATH 20 min YEARS
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 420.0			20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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) _____		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 May 23 , 19 57 , to Sept. 21 , 19 57 that I last saw the deceased alive on Sept. 21, 191957 and that death occurred at 6:21 AM from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J. Carl Smith, M.D.				23b. ADDRESS 5600 Grand		23c. DATE SIGNED 9-21-57	
24a. BURIAL CREMATION REMOVAL (Specify) Removal		24b. DATE Sep 24 57	24c. NAME OF CEMETERY OR CREMATORY Valhalla		24d. LOCATION (City, town, or county) (State) St. Louis Cty Mo.		
DATE REC'D BY LOCAL REG. SEP 23 57		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.J. Schnur 3125 Lafayette			

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

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

1935-10-10

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SEX
AGE
RACE
RELIGION
MARRIAGE

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 *Thomas R. Fenwick*

Licensed Embalmer No. 3793

P.O. Address 3125 Lafayette

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.