

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007785
STATE FILE NUMBER

FILED MAR 5 - 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2125

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Perry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Pinckneyville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		Length of stay in lb <u>1 week</u>	d. STREET ADDRESS (If outside, give location) <u>203 E. Chester St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Sophia</u> Middle <u>Carolina</u> Last <u>Schroeder</u>			4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1881</u>	9. AGE (In years birthday) <u>76</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Perry Co., Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

13a. FATHER'S NAME <u>Fred Ahlers</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Bischof</u>		14. NAME OF HUSBAND OR WIFE <u>Unavailable</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Francis Schroeder, Glendale, Cal.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>NEPHROSCLEROSIS</u> DUE TO (c) <u>446x</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>HEMORRHAGE FROM GASTROINTESTINAL TRACT.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>Feb. 8, 1958</u> to <u>Feb. 20, 1958</u> and last saw her/him alive on <u>Feb. 19, 1958</u> Death occurred at <u>3:15AM Feb. 20, 1958</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert E Koch, M.D.</u>		22b. ADDRESS <u>35 N. Central, Clayton 5, Mo.</u>	22c. DATE SIGNED <u>2-21-58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-20-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mueller Hill</u>	23d. LOCATION (City, town, or country) (State) <u>Perry Co., Ill.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 21 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith Mo</u> <u>ms</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Robert M. Murray*

Licensed Embalmer No. *37490*
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.