

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-012775

STATE FILE NUMBER

FILED MAR 24 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 789

300  
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Secretary, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Jennings</b> <b>4138</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Normandy Osteo. Hosp.</b>		Length of stay in lb <b>8 Days</b>	d. STREET ADDRESS (If outside, give location) <b>8804 Clifton Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>P.</b> Last <b>SCHUPPMAN</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>17</b> Year <b>1958</b>		
5. SEX <b>Male</b> <b>0</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 20, 1920</b>	9. AGE (In years last birthday) <b>37</b>	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) <b>Machinist-Century Electric Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electric Co.</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo. 0</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Charles A. Schuppman</b>		13b. MOTHER'S MAIDEN NAME <b>Cecelia C. Muenks</b>	
14. NAME OF HUSBAND OR WIFE <b>Alta Schuppman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>499-12-9074</b>	
17. INFORMANT <b>Alta Schuppman</b>		Address <b>8804 Clifton Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>insufflation of vomitus</b>					<b>Intubation.</b>
DUE TO (c) <b>Peritonitis and Pleus 5701</b>					<b>7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Acute hemorrhagic necrotizing pancreatitis</b>					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 Month, Day, Year a.m. p.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>3/10/58</b> to <b>3/17/58</b> and last saw <b>him</b> alive on <b>3/17/58</b> Death occurred at <b>10:05 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>D. P. Gardner M.D.</b>			22b. ADDRESS <b>917 Clifton Ave.</b>		22c. DATE SIGNED <b>3/18/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 20, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>
24. FUNERAL DIRECTOR <b>Kriegshauser</b>		ADDRESS <b>4228 S. Kingshighway</b>		25. DATE RECD. BY LOCAL REG. <b>3-18-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert P. Donke M.D.</b>

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 *Richard W. Stovess*

Licensed Embalmer No. *4007*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.