

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-020115  
STATE FILE NUMBER

FILED MAY 16 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4959

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-57

|   |                           |  |                                  |  |                                |
|---|---------------------------|--|----------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY   |                                  |  |                                |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis  |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                                  | c. CITY OR TOWN St. Louis  |                                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION Bethesda Hospital  |                           | Length of stay in 1b<br>36 yrs.  |                                  | d. STREET ADDRESS (If outside, give location)<br>2733 LaSalle St.  |                                |
| 3. NAME OF DECEASED (Type or print)<br>First MIDDLE LAST<br>ALBERT J. SCHLATHER   |                           | 4. DATE OF DEATH<br>Month Day Year<br>May 8, 1958  |                                  |  |                                |
| 5. SEX<br>Male <input type="checkbox"/>   | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br>July 1, 1880 | 9. AGE (In years less birthday)<br>77                              | IF UNDER 1 YEAR<br>Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Florist  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Wholesale Florist   |                                  | 11. BIRTHPLACE (City and state or country)<br>Jebenhausen, Germany |                                |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                           | 13a. FATHER'S NAME<br>Christian Schlather  |                                  | 13b. MOTHER'S MAIDEN NAME<br>Rosina Mayer                          |                                |
| 14. NAME OF HUSBAND OR WIFE<br>None   |                           | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No  |                                  | 16. SOCIAL SECURITY NO.<br>---                                     |                                |
| 17. INFORMANT<br>Address<br>The deceased on Aug. 27, 1954   |                           | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Generalized Carcinomatous Growth</i><br>DUE TO (b) <i>Carcinoma of rectum (resected 5 years ago)</i><br>DUE TO (c)<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                  | INTERVAL BETWEEN ONSET AND DEATH                                   |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><i>Arteriosclerosis Heart disease 154x</i>   |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |                                |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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<br>Hour Month, Day, Year<br>a.m. p.m.   |                           |  |                                  |  |                                |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK 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 <i>Feb 13<sup>th</sup> 58</i> to <i>May 8<sup>th</sup> 58</i> and last saw <sup>her</sup> him alive on <i>May 8<sup>th</sup> 1917</i><br>Death occurred at <i>3:00 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated. |                           | 22a. SIGNATURE (Degree or title)<br><i>Emmet Younger, M.D.</i>   |                                  | 22b. ADDRESS<br><i>3624 Russell</i>                                |                                |
| 22c. DATE SIGNED<br><i>5-9-58</i>   |                           | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal   |                                  | 23b. DATE<br>May 10, 1958  |                                |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Hiram Cemetery  |                           | 23d. LOCATION (City, town, or county) (State)<br>St. Louis County, Missouri  |                                  |  |                                |
| 24. FUNERAL DIRECTOR<br>Beiderwieden F.H.Inc. 1936 St.Louis   |                           | 25. DATE RECD. BY LOCAL REG.<br>MAY 10 58  |                                  | 26. REGISTRAR'S SIGNATURE<br><i>J. Earl Smith, M.D.</i><br>S.P.    |                                |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

8624  
9-11 am

MAY 26 1958

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 [Signature]  
\_\_\_\_\_

Licensed Embalmer No. 452

P. O. Address [Signature]

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.