

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038190

STATE FILE NUMBER

FILED OCT 17 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9583

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Chronic Hospital</i>		Length of stay in lb <i>2 wks. 20/58</i>	d. STREET ADDRESS (If outside, give location) <i>4142 Tyrolean</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Henry</i> Middle <i>W.</i> Last <i>Schaeffer</i>			4. DATE OF DEATH Month <i>10</i> Day <i>4</i> Year <i>58</i>			
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5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 16, 1895</i>	9. AGE (In years last birthday) <i>62</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired member</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>St. Louis Fire Dept.</i>	11. BIRTHPLACE (City and state or country) <i>Ill.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>William Schaeffer</i>	13b. MOTHER'S MAIDEN NAME <i>Unknown</i>	14. NAME OF HUSBAND OR WIFE <i>Lillian (deceased)</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>Yes W.W.I.</i>	16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT <i>Vernon Schaeffer</i>	Address <i>2007 Spanish Drive</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>Generalized Arteriosclerosis</i>		<i>1 mo.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Diabetes Mellitus - 25 yrs.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <i>443x</i>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <i>9-23-58</i> to <i>10-4-58</i> and last saw ^{her} him alive on <i>10-4-58</i> Death occurred at <i>9:55 p.m.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>	22b. ADDRESS <i>5800 Arsenal St.</i>	22c. DATE SIGNED <i>OCT 6 '58</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>10-8-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>National Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Jefferson Barrades, Mo.</i>
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24. FUNERAL DIRECTOR <i>Thomas Kutis</i>	ADDRESS <i>2906 Gravois Ave.</i>	25. DATE RECD. BY LOCAL REG. <i>OCT 6 '58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Leo J. Budde

Licensed Embalmer No. *3989*

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.