

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015690

STATE FILE NUMBER

Registrar **2** 2805

FILED MAY 1 1959

Registration District No.

Primary Registration District No.

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>2206 S. 11TH</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED First Middle Last  
**Joseph A. Schoemehl**

4. DATE OF DEATH Month Day Year  
**March 16, 1959**

5. SEX <b>M</b>	6. COLOR OR RACE <b>W</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>AUG 17, 1906</b>	9. AGE (In years last birthday) <b>52</b>	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) <b>Tavern Owner</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>FRANK SCHOEMEHL</b>	13b. MOTHER'S MAIDEN NAME <b>CATHERINE BOING</b>	14. NAME OF HUSBAND OR WIFE <b>STELLA SCHOEMEHL</b>
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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) <b>Yes W.W.II</b>	16. SOCIAL SECURITY NO. <b>499-01-8079</b>	17. INFORMANT Address <b>STELLA SCHOEMEHL 2206 S. 11TH</b>
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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) **Carcinoma of lung**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) **1637A**

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
**Far Advanced Pulmonary Tuberculosis**

19. WAS AUTOPSY PERFORMED? YES  NO

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.)
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20c. TIME OF INJURY Hour Month, Day, Year  
a.m. p.m.

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
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21. I attended the deceased from **Mar 10, 1959** to **Mar 16, 1959** and last saw <sup>him</sup> alive on **Mar 16, 1959**  
Death occurred at **9:45 pm** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Donald A. Gustafson, M.D.</i>	22b. ADDRESS <b>1515 Lafayette ave</b>	22c. DATE SIGNED <b>3-16-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>MAR 20, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>JEFFERSON BARRACKS, Mo</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Thomas Kute 2906 Gravois</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 19 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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*mjb*

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 *Eleanora Prince*

Licensed Embalmer No. *3403*

P. O. Address *Lawrence, N.J.*

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.