

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-034279

STATE FILE NO. 8728
REGISTRATION NO.

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo.		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hos'p		d. STREET ADDRESS (If outside, give location) 5771 Waterman	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle A. Scharff Last			4. DATE OF DEATH Month 9 Day 21 Year 1959
5. SEX male	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/13/1877
9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairs		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (City and state or country) St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Isaerus Scharff	
13b. MOTHER'S MAIDEN NAME Eiseman		14. NAME OF HUSBAND OR WIFE Gertrude M. Scharff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Arthur Scharff Jr. 77 Lake Forest
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) congestive Heart Failure DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0			INTERVAL BETWEEN ONSET AND DEATH 2 days 7 days 15 years
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <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.) ITEM 8 CORRECTED		BY: 1. AFFIDAVIT OF Funeral Director 2. DOCUMENT Ed. of Elect. Comm. Records	
20c. TIME OF INJURY Hour Month, Day, Year 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	
21. I attended the deceased from 10/8/53 to 9/20/59 and last saw him alive on 9/20/59 Death occurred at 9/21/59 9P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Harold Scheff M.D.		22b. ADDRESS 100N. Euclid St. Louis 8, Mo.	
22c. DATE SIGNED 9/21/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 9/23/59	
23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai		23d. LOCATION (City, town, or county) (State) 8400 Gravois Ave	
24. FUNERAL DIRECTOR Mayer Funeral Home, 4356 Lindell Blvd.		25. DATE RECD. BY LOCAL REG. SEP 22 '59	
26. REGISTRAR'S SIGNATURE Harold Smith, M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Securing the medical certification in the specific manner required by 193.140 MoKS 1949.

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 *Stanley H. Ripon*

Licensed Embalmer No. *4193*

P. O. Address *S. R.*

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.