

FEDERAL BUREAU OF INVESTIGATION  
**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-037355**

**FILED VS OCT 27 1959** 316

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **408**

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Perry</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Francois Township</b>		Length of stay in 1b <b>5M; 21 days</b>		c. CITY OR TOWN <b>Perryville</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital No. 4</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Star Route</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>MARY</b> Last <b>SCHEMEL</b>				4. DATE OF DEATH Month <b>October</b> Day <b>20</b> , Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 12, 1884</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Biehle, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Carl Biehle</b>			13b. MOTHER'S MAIDEN NAME <b>Minna Gebhardt</b>			14. NAME OF HUSBAND OR WIFE <b>William A. Schemel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>498-18-4815</b>		17. INFORMANT Address <b>Records, State Hospital No. 4, Farmington, Mo</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>Lobar pneumonia - - - - -</b>							INTERVAL BETWEEN ONSET AND DEATH <b>abt. 3 das.</b>
DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Psychosis with cerebral arteriosclerosis, and fracture of neck of left femur (9-24-59).</b>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Fell when pushed by another mental patient.</b>				
20c. TIME OF INJURY <b>10:00 A.M.</b>	Month, Day, Year <b>9-24-59.</b>						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Ward of mental hospital.</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Farmington-St. Francois Co. Mo.</b>			
21. I attended the deceased from <b>April 29, 1959</b> to <b>Oct. 20, 1959</b> and last saw her <b>live</b> on <b>Oct. 20, 1959</b> Death occurred at <b>11:00 A. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>John A. Brennan, M.D.</b>				22b. ADDRESS <b>State Hospital No. 4 Farmington, Missouri</b>		22c. DATE SIGNED <b>10-20-59</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/20/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Maurus Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Biehle Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Young &amp; Sons Perryville, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>Oct. 20, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Ether Rudloff</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6961 & 1 AON SA  
NOV 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 Edward S. Young

Licensed Embalmer No. 2138

P. O. Address Perryville, 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.