

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-038063**

**FILED VS. OCT. 19 1959**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **2 8646**

UNRECORDED

<b>1. PLACE OF DEATH</b> a. COUNTY <del>St. Louis</del>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>1 day</b>		c. CITY OR TOWN <b>Lemay</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>728 Karlsruhe</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>EMMA</b> Middle <b>SCHOPFER</b> Last <b>SCHOPFER</b>				<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>18</b> , Year <b>1959</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8/22/1870</b>	<b>9. AGE (last birthday)</b> <b>89</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At Home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Switzerland</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>		
<b>13a. FATHER'S NAME</b> <b>John Yost</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Verena Eseli</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Oscar Joseph Schopfer</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>Mrs. Joseph B. Kemper, 728 Karlsruhe, Lemay</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b>								
DUE TO (c) <b>331X</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)						
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____								
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b> <b>STATE</b>		
<b>21. I attended the deceased from</b> <b>4 Mar 1957</b> to <b>Sept 1959</b> and last saw her <b>alive on</b> <b>9-18-59</b> Death occurred at <b>11:30 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> <i>Leo J. [Signature]</i> (Degree or title)				<b>22b. ADDRESS</b> <b>1408 Telegraph St</b>		<b>22c. DATE SIGNED</b> <b>9-19-59</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>	<b>23b. DATE</b> <b>September 21, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Sunset Burial Park</b>		<b>23d. LOCATION (City, town, or county)</b> <b>St. Louis County, Missouri.</b>		(State)		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Beiderwieden F.H.Inc., 1936 St. Louis</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>SEP 21 '59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Leo Smith, M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

101 W. 2-6-22  
- Till '3

**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 

Licensed Embalmer No. 4520  
P. O. Address St. Louis

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.