

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

**FILED VS MAY 6 1960**

**=60-017303**

**2 4476**

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <b>St. Louis, Missouri</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Franklin, Mo.</b> c. CITY OR TOWN <b>Frank Clay, Mo.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in lb <b>short stay</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>died in office 1467 Union Blvd.</b>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>JOSEPHINE SCHEERIN</b>	First <b>JOSEPHINE</b>	Middle <b>SCHEERIN</b>	Last	4. DATE OF DEATH <b>April 25, 1960</b>	Month <b>April</b>	Day <b>25</b>	Year <b>1960</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</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>7/13/1882</b>	AGE (last birthday) <b>77 yr.</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if called) <b>unable to work</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>household duties</b>	11. BIRTHPLACE (City and state or country) <b>Pilot Knob, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>MISSOURI</b>
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13a. FATHER'S NAME <b>Burd Jones</b>	13b. MOTHER'S MAIDEN NAME <b>Emmline Beard</b>	14. NAME OF HUSBAND OR WIFE <b>Tom Scheerin</b>
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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>Unknown</b>	17. INFORMANT <b>Letha Maxfield</b>	Address <b>6142 Plymouth Ave.</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) <b>Myocardial Infarction 420.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
DUE TO (b) <b>Arteriosclerotic hypertensive heart disease 20 mo.</b>		
DUE TO (c) <b>chronic ear, nose &amp; throat infection</b>		<b>1958</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cystocele with urinary frequency</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
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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.) <b>none</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 <b>Leadwood, Mo.</b>	COUNTY <b>Leadwood, Mo.</b>	STATE
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21. I attended the deceased from **Aug. 12, 1958** to **Apr. 25, 1960** and last saw her alive on **530 P.M. 4/25/60**  
Death occurred at **5:30 P.M. Apr. 25, 1960** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Henry E. Rosenberg M.D.</b>	(Degree or title) <b>M.D.</b>	22b. ADDRESS <b>1467 Union Blvd. St. Louis, Mo.</b>	22c. DATE SIGNED <b>4/25/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4-28-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Leadwood Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Leadwood, Mo.</b>
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24. FUNERAL DIRECTOR <b>Boyer Funeral Home, Leadwood, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>APR 26 1960</b>	26. REGISTRAR'S SIGNATURE <b>Lead Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4596

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.