

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-004469

318

1003

414

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

AMENDED

FILED JAN 23 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>3 weeks</u>	c. CITY OR TOWN <u>E. St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Barnes Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1304 N. Park Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>AUGUST</u> Middle <u>E</u> Last <u>SCHAEFER</u>			4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1962</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1902</u>	9. AGE (last birthday) <u>59</u>	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 retired) <u>Owner & Opr.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Service Station</u>	11. BIRTHPLACE (City and state or country) <u>E. St. Louis, Ill</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Henry Schaefer</u>	13b. MOTHER'S MAIDEN NAME <u>Rose Steiner</u>	14. NAME OF HUSBAND OR WIFE <u>Ann (Lundy) Schaefer</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT <u>Mrs. Ann Schaefer - E. St. Louis, Ill</u>	Address
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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) <u>RENAL HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNDETERMINED</u>
DUE TO (b) _____		446x
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>BRONCHOPNEUMONIA. CEREBRAL HEMORRHAGE, SUSPECTED</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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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	COUNTY	STATE
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21. I attended the deceased from DEC. 20, 1961 to JAN. 9, 1962 and last saw her/him alive on JAN. 9, 1962
Death occurred at 2:40 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>C. D. Vermillion, M.D., M. D.</u> (Degree or title)	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>1/10/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-12-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Belleville, Illinois</u>
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24. FUNERAL DIRECTOR <u>C. G. Kurrus, Jr</u>	ADDRESS <u>E. St. Louis, Ill</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 10 1962</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1981 10 17 10:14

*Miss Gail
C. ...*

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

Not Embalmed
Barry J. ...
Signed _____

Licensed Embalmer No. 3162 *C. ...*

P. O. Address E. St. Louis, Illinois

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.