

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED FEB 23 1962

1904-62-007908  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No.

AMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>3 yrs 4mo.</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>814 Russell</b>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Caroline</b> Middle <b>Conway</b> Last			4. DATE OF DEATH Month <b>Feb.</b> Day <b>14</b> Year <b>1962</b>		
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</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>6-2-1875</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months Days Hours Min.	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) <b>Laundry</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>St. Lukes Hosp.</b>	11. BIRTHPLACE (City and state or country) <b>Paducah, Ky.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Michael Schaff</b>	13b. MOTHER'S MAIDEN NAME <b>Catherine Buser</b>	14. NAME OF HUSBAND OR WIFE <b>George A. (dcd)</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 None</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Edmond C. Conway-8903 Window</b>	Address <b>Overland 14</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>Left bronchopneumonia</b> <i>Left Bronchopneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <i>8 days</i>
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>Arteriosclerotic Heart Disease - 3 1/2 yrs</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>491x</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>Overland 14, Missouri</b>
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21. I attended the deceased from <b>10-9-58</b> to <b>2-14-62</b> and last saw her alive on <b>2-14-62</b> Death occurred at <b>12:45 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>John W. Beekman, M.D.</i>	22b. ADDRESS <b>5800 Ardenal</b>	22c. DATE SIGNED <b>2/14/62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2-17-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Overland 14, Missouri</b>
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24. FUNERAL DIRECTOR <b>BAUMANN BROS. INC. FUNERAL HOME</b> <b>2504 WOODSON ROAD</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 15 1962</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 STATE AMENDED  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address St. 74 me

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.