

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-022493

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1596

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 4031

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAY 27 1963		
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Saint Louis</b></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Normandy Osteopathic Hosp.</b></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b></p> <p>c. CITY OR TOWN <b>Pagedale</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <b>6728 Schofield</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type, or print)</p> <p>First <b>Clara</b> Middle <b>Agnes</b> Last <b>Bischoff</b></p>	<p>4. DATE OF DEATH</p> <p>Month <b>May</b> Day <b>14</b> Year <b>1963</b></p>	
<p>5. SEX <b>Female</b></p>	<p>6. COLOR OR RACE <b>White</b></p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>
<p>8. DATE OF BIRTH <b>2-6-1888</b></p>	<p>9. AGE (last birthday) <b>75</b></p>	<p>IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b></p>	
<p>11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b></p>	<p>12. CITIZEN OF WHAT COUNTRY <b>U S A</b></p>	
<p>13a. FATHER'S NAME <b>Ernest Klittich</b></p>	<p>13b. MOTHER'S MAIDEN NAME <b>Anthony</b></p>	<p>14. NAME OF HUSBAND OR WIFE <b>William Bischoff</b></p>
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)</p>	<p>16. SOCIAL SECURITY NO. <span style="background-color: black; color: black;">XXXXXXXXXX</span></p>	
<p>17. INFORMANT Address <b>Mrs Clara Estinger 3421 Emirence Avenue</b></p>		
<p>18. CAUSE OF DEATH (Enter only one cause per line for part I and II)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <b>Acute Circulatory Collapse</b></p> <p style="text-align: center;">DUE TO (b) <b>Coronary Thrombosis</b></p> <p style="text-align: center;">DUE TO (c) <b>Myocardial Insufficiency</b></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>acute</b></p> <p><b>acute</b></p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>		
<p>20c. TIME OF INJURY Hour Month, Day, Year</p> <p>a.m. p.m.</p>		
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>		
<p>21. I attended the deceased from <b>1/1962</b> to <b>5-14-63</b> and last saw her/him alive on <b>5-13-63</b></p> <p>Death occurred at <b>8:10 a.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>		
<p>22a. SIGNATURE <b>[Signature]</b> (Degree or title)</p>		<p>22b. ADDRESS <b>1820 Park (33)</b></p>
<p>22c. DATE SIGNED <b>5-14-63</b></p>		
<p>23a. BURIAL, CREMATION, REMOVAL (specify) <b>Burial</b></p>	<p>23b. DATE <b>May 17, 1963</b></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Gardens</b></p>
<p>23d. LOCATION (City, town, or county) (State) <b>St. Louis County Missouri</b></p>		
<p>24. FUNERAL DIRECTOR ADDRESS <b>Shepard Funeral Chapel 9255 Natural Bridge</b></p>		<p>25. DATE RECD. BY LOCAL REG. <b>5-16-63</b></p>
<p>26. REGISTRAR'S SIGNATURE <b>[Signature]</b></p>		

USE BLACK INK OR TYPEWRITER RIBBON

**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,

~~\_\_\_\_\_~~ \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer...

Signed

*Lawrence O. Herling*

Licensed Embalmer No. 4979

P. O. Address Berkeley, 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.