

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. 787

Township.....

Primary Registration District No. 1008

City St. Louis

(No. City Infirmary)

File No. 28653

Registered No. 8110

St. _____ Ward)

2. FULL NAME

Otto Schrader

(a) Residence. No. St. Louis - 1st Infirmary St. 2213 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 4 mos.

ds. How long in U.S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

White

5. ~~Single or married~~ WIDOWED OR

Widow - 1

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

June 11 - 1858

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1
day, _____ hrs.
or _____ min.

74

1

24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

Sailor

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

10. NAME OF FATHER

Karl Schrader

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Elsie Papendicken

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14. INFORMANT

(Address)

Mrs. Effinger
5800 Arsenal St.

15. FILED

1928

Wm. C. Storkel
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR)

August 4th 1928

17.

I HEREBY CERTIFY That I attended deceased from 4-12-1928, to 8-4-1928,
that I last saw him alive on August 4th 1928, and that
death occurred, on the date stated above, at 9:00 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
577013
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

Chronic arthritis
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Paul H. Hoz M. D.

(Address) City Hospital

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

POTTETS FIELD

8-10-1928

20. UNDERTAKER

ADDRESS

Wm. White 5800 Arsenal

Exact statement of OCCUPATION is very important.

