

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

Do not use this space.

20494

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1. PLACE OF DEATH

County St. Louis Registration District No. 795
 Township Bottoms Primary Registration District No. 6031
 City Ellisville Mo (No. Ellisville Mo)

File No. _____
 Registered No. 134 St. _____ Ward _____

2. FULL NAME

Louis C. Schader
 (a) Residence No. Ellisville Mo St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Caroline Schader</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 17 1859</u>		
7. AGE YEARS <u>71</u>	MONTHS <u>2</u>	DAYS <u>12</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Buyer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>retired 72y</u> (c) Name of employer <u>Redeem Commission Co</u>		
9. BIRTHPLACE (CITY OR TOWN) <u>St. Louis Mo.</u> (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER <u>Frederick Schader</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
	12. MAIDEN NAME OF MOTHER <u>Sybil Koenig</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
14. INFORMANT <u>Caroline Schader</u> (Address) <u>Ellisville Mo.</u>		
15. FILED <u>7/8 1930</u> <u>C. E. Barnett M.D.</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29 1930

17. I HEREBY CERTIFY, That I attended deceased from June 15 June 29 1930 to June 29 1930 that I last saw him alive on June 15 1930 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
124B
131 (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) Chronic Cystitis (duration) 2 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED At Home
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Phys. Exam
 (Signed) Geo. W. ... M.D.
 (Address) 3532 Washington

*State the DISEASE CAUSING DEATH, or in 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 <u>Sunset Burial Park</u>	DATE OF BURIAL <u>July 2 1930</u>
20. UNDERTAKER <u>Kriegerhaus & Co.</u>	ADDRESS <u>4238 Kingshighway</u>

WHITE PLAIN, WITH UNFADING INK---THIS IS PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

