

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

File No. **16135**
Registered No. **4612**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
1003
Township _____ Primary Registration District No. _____
City **St. Louis Mo** (No. **4501** **Athens**)

2. FULL NAME

Henry W. Schaefering
(a) Residence. No. **4501 Athens** St. **9** 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 Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Wilhelmina

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **9-13-1854**

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
76	76	7	2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Retired**
(b) General nature of industry, business, or establishment in which employed (or employer) **Carrriage Painter**
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) **St. Louis Mo**
(STATE OR COUNTRY) _____

10. NAME OF FATHER **Ernst Schaefering**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER **Unknown**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Unknown**
(STATE OR COUNTRY) _____

14. INFORMANT **Wilhelmina Schaefering**
(Address) **4501 Athens Ave.**

15. FILED **1936**
Wm. C. Storkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) **Apr. 15th 10⁴⁵ PM. 1931**
17. **No physician in attendance**
I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at **10:45 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & injuries (hemorrhage of Brain - Fractured Skull) received in fall down stairs at residence 1864 1/2 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **accident** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **1864 1/2**
IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? **yes**
WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) **John Henry** M. D.
4/17, 1931 (Address) **1001 1/2 North Crown**
*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 **Western Lutheran** DATE OF BURIAL **Sat. Apr. 19 1931**
20. UNDERTAKER **Theo. Biederweiden** ADDRESS **1926 St. Louis Ave.**

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.

