

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.

MAR 24 1934

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

Do not use this space.

7136

File No. _____
 Registered No. **2018**
 St. _____ Ward _____

PLACE OF DEATH

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

1. FULL NAME **Kate Schoenhard**
 (a) Residence, No. **3861** (Usual place of abode) **Ward.**
 Length of residence in city or town where death occurred **78** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **William F. Schoenhard**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sept 23 1855**

7. AGE YEARS **78** MONTHS **3** DAYS **3** If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Unknown**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **Unknown**

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

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

13. NAME **Unknown**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

15. MAIDEN NAME **Unknown**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

17. INFORMANT **Wm Luf M. Key** (ADDRESS) **Osceola**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Frederick** DATE **Feb 28** 19**34**

19. UNDERTAKER **A. Cron & Co** (ADDRESS) **2409 W. Grand Blvd**

20. FILED **FEB 26 1934** **J. Brebeck** Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2/26** 19**34**

22. I HEREBY CERTIFY, That I attended deceased from **2/21** 19**34** to **2/26** 19**34**

I last saw him alive on **2/26** a. m. 19**34**. Death is said to have occurred on the date stated above, at **2:43** p. m.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
Arteriosclerosis
Senile Calcification
 Date of onset **2-21-34**

Name of operation _____ Date of _____
 What test confirmed diagnosis? **Clinical** Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19**34**

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____

(Signed) **William A. Hines** M. D.
 (Address) **City of St. Louis**

