

NOV 15 1937

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

 36180  
 Do not use this space.

## 1. PLACE OF DEATH

- (a) County ..... Registration District No. **791**  
 (b) Township ..... Primary Registration District No. **21003**  
 (c) City **St. Louis** (d) Street No. **4454 Delor St.** Registered No. **9757** St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Fred Schlemmer**

- (a) Residence, No. **4454 Delor St.** St. **13**  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <b>M</b>	4. COLOR OR RACE <b>W</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Widowed</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Pauline</b>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>April 5th 1863</b>		
7. AGE <b>74</b>	YEARS <b>6</b>	MONTHS <b>15</b>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <b>Sta. Engineer</b>		11. Total time (years) spent in this occupation
9. Industry or business in which work was done, as saw mill, bank, etc.		10. Date deceased last worked at this occupation (month and year)
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct 20**, 19**37**  
 22. I HEREBY CERTIFY, That I attended deceased from **April - 10**, 19**36**, to **Oct - 20**, 19**37**  
 I last saw him alive on **Oct - 20**, 19**37**. Death is said to have occurred on the date stated above, at **4:12 P. m.**  
 The principal cause of death and related causes of importance were as follows:

**Chronic Myocarditis****93C**

Other contributory causes of importance:

**Arterio Sclerosis**

Date of onset

**unknown**

Name of operation..... Date of.....

What test confirmed diagnosis?..... 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

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) **F. P. Habis**, M. D.(Address) **5817 1/2 Carver**

OCCUPATION

2027

FATHER

MOTHER

31

31

18

19

20

OCT 21 1937

Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

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.

**STATEMENT BY LICENSED EMBALMER**

I, C. P. Kidwell, Licensed Embalmer No. 3877

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

*Clarence P. Kidwell*

Licensed Embalmer No. 3877

**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.)**