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.

FILED MAY 10 1939

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

13610
Do not use this space.

791
1003
3952

1. PLACE OF DEATH

(a) County ..... Registration District No. 2

(b) Township ..... Primary Registration District No. ..... Registered No. .....

(c) or City Saint Louis, Missouri. (d) Street No. 3317 California Ave. 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 120 Pauline Schaback

(a) Residence, No. 3317 California Ave. St. 24
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) October 12th, 1860.

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
78	6	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home

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) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saint Louis, Missouri

FATHER

13. NAME ? Heder

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

MOTHER

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Henry E. Telthorst 3317 California Ave.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Bellefontaine Cem. DATE April 29th, 1939.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ziegenhein Bros. 2623 Cherokee Street.

20. FILED APR 28 1939 J. F. Budick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 27th, 1939.

22. I HEREBY CERTIFY, That I attended deceased from 1937 to 19..., to April 26th, 1939
I last saw her alive on April 26th 1939 Death is said to have occurred on the date stated above, at 1:30A.M.
The principal cause of death and related causes of importance were as follows:

Chronic Interstitial Nephritis

Date of onset

Other contributory causes of importance: Myocarditis

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

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) Dr John Buschman, M. D.
(Address) 1625 S. Jefferson

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed V E Morris

Licensed Embalmer No. 3360

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.