

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33573

Registration District No. 784

Primary Registration District No. 200

State File No. _____

Registrar's No. 1713

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Rural Carondelet Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Route 8 Box 490 Hawkins Rd.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether

In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 1

(c) City or town Rural Carondelet
(If outside city or town limits, write "RURAL")

(d) Street No. Hawkins Road
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Henry A. Schroeter 636

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Bertha

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 18 1860
(Month) (Day) (Year)

8. AGE: Years 78 Months 10 Days 20
If less than one day hr. _____ min.

9. Birthplace St. Louis Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Himself

MOTHER FATHER

12. Name August Schroeder

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Mary Schuette
(City, town, or county) (State or foreign country)

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature A. C. Schroeder

(b) Address Rt. #8 Box 490 Lemay, Mo.

17. (a) Burial (b) Date thereof Oct. 1, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old St. Johns Cemetery

18. (a) Signature of funeral director C. Hoffmeister

(b) Address 7814 S. Broadway

19. (a) SEP 30 1939 (b) R. Meyer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 28
year 1939 hour 5 minute 50 P. M.

21. I hereby certify that I attended the deceased from Sept. 28 1939
and that I last saw him live on Sept. 28 1939
and that death occurred on the date and year stated above.

Immediate cause of death Myocardial Infarction Duration _____

Due to Weakness due to age

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Mitral Stenosis

Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 1

23. Signature D. R. ...
Address 710 ... Date signed 9-30-39

7710 Michigan
Ri 0082

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 Edwin H. Lebing

Licensed Embalmer No. 4049

P. O. Address 6464 Alppewa

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.)

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

335-73
Do not use this space.

1. PLACE OF DEATH
 (a) County St Louis Registration District No. 784
 (b) Township Carondelet Primary Registration District No. 200
 (c) City _____ (d) Street No. _____ St.
 (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 Henry A Schroeter correct
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
78 10 20
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 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) _____
 FATHER 13. NAME August Schroeter
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Schroeter
 MOTHER 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19 _____
 19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED 9-30 1939 JR. Maynard D. DPH Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-28 1939
 22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____.
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
 _____ Date of onset _____
 Other contributory causes of importance:

 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) D. Royal V. Tubbs, M. D.
 (Address) 711 d. Murphy

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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