DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS 791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34245

Registration District No. 1003 Primary Registration District No. Registrar's No. 8783

1. PLACE OF DEATH:

REC'D NOV 13 1939

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
City Hospital, #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 Days
In this community 66 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St Louis 23
(If outside city or town limits, write "RURAL")

(d) Street No. 1510½ So 7th St
(If rural, give location)

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

3. (a) PRINT FULL NAME Theresa Scheik

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife William Charles Schiek

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased October 17th. 1877
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
~~85~~ 62	11	26	hr. min.

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

10. Usual occupation housewife

11. Industry or business at home

MOTHER FATHER

12. Name Thomas Schmidt

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

14. Maiden name Theresa Chenoster

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

16. (a) Informant's own signature Anthony Schiek

(b) Address 1510A So. Tenth Str.

17. (a) BURIAL 3069 (Burial, cremation, or removal) (b) Date thereof Oct. 16, 39 (Month) (Day) (Year)

(c) Place: burial or cremation New Picker Cemetery

18. (a) Signature of funeral director Henry Hendemueller

(b) Address 6203 Gravois Ave

19. (a) OCT 16 1939 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 13, year 1939 hour 9:35 minute P. M.

21. I hereby certify that I attended the deceased from September 29, 39, to October 13, 39; that I last saw her alive on October 13, 39 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral apoplexy	
Hypertensive Heart Disease	
Due to Arteriosclerosis, general	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address 1515 Lafayette, Date signed 10/14/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 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 Albert G Hoppe

Licensed Embalmer No. 2941

P. O. Address.....

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.

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.

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

34245

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791

(b) Township..... Primary Registration District No. 1003 Registered No. 8783

(c) City St Louis (d) Street No..... 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 Theresa (Schiek) SCHIEK

(a) Residence, No..... St.

(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 F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm Charles Schiek

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	11	28	

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

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

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 7/15/39 19 J F Bredeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-13 1939

22. I HEREBY CERTIFY, That I attended deceased from 19 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) F. S. Hampton, M. D.

(Address) 1515 Lafayette

SUPPLEMENTARY