

JAN 12 1940

791

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **11215**

1. PLACE OF DEATH:

(a) County _____ **2**

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

(c) Name of hospital or institution:
3016 Miami
(If not in hospital or institution, write street number or location)

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

In this community **15 years**
years, months or days

3. (a) PRINT FULL NAME **Minnie Schroeder 636**

8. (b) If veteran, name war _____ **8. (c) Social Security** No. _____

4. Sex **Female** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Widowed**

6. (b) Name of husband or wife **Anton** **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased **Nov. 26, 1866**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
73	1	3	_____ hr. _____ min.

9. Birthplace **Pilot Knob Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Home**

11. Industry or business _____

MOTHER FATHER

12. Name **Wm. Biel**

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

14. Maiden name **Unknown**

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

16. (a) Informant's own signature **Mrs. Etta Christerson**

(b) Address **3016 Miami**

17. (a) Burial **(b) Date thereof** **1/2/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **O. SS. Peter & Paul**

18. (a) Signature of funeral director **Wacker - Welderle**

(b) Address **2331 S. Broadway**

19. (a) 550-30-1939 **(b) J. B. Beck**
(Date of issue of death certificate) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **1**

(c) City or town **St. Louis, Mo.** **24**
(If outside city or town limits, write "RURAL")

(d) Street No. **3016 Miami St.**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec. 29th**
year **1939** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **Oct. 17th, 1939, to Dec. 29th, 1939**
that I last saw her alive on **Dec. 28th, 1939**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Myocarditis**

Chronic Diabetes **2 Yr.**

Chronic Interstitial

Nephritis **6 Mo**

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

Major findings: _____
Of operations _____

Of autopsy **No**

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 _____

23. Signature **Dr. W. A. Walters, M.D.**
Address **3608 So. Grand Blvd.** Date signed **12/29/39**

Duration

1 wk

2 Yr.

6 Mo

PHYSICIAN

Underline the cause to which death should be charged statistically

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.....

Licensed Embalmer No.....

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.