

FILED APR 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8696
Registrar's No. 2179

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4621 Quincy 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community 40 years

3. (a) PRINT FULL NAME Marie Sophie Schroeter

3. (b) If veteran, name war _____ 3. (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 Richard (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 4, 1850
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>89</u>	<u>9</u>	<u>27</u>	hr. _____ min. _____

9. Birthplace Not known Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Mildner

13. Birthplace Not known Germany
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Paul Schroeter

(b) Address 4621 Quincy

17. (a) burial (b) Date thereof 3/4/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation burial Lakewood Park

18. (a) Signature of funeral director John T. Zepfenauer

(b) Address 7027 Broadway

19. (a) MAR 4 1940 (b) _____
(City, town, or county) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 2
(If outside city or town limits, write "RURAL")
(d) Street No. 4621 Quincy
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 40 years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11
year 1940 hour 3 minute _____ M.

21. I hereby certify that I attended the deceased from Feb 17, 1940 to March 11, 1940
that I last saw him alive on March 1, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Tubercular Pneumonia

Due to _____

Due to _____

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

Major findings: Of operations _____ Of autopsy _____

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 J. J. [Signature] (M. D. or other) _____
Address 2102 [Address] Date signed 3-4-40

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

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.

Rev. 5-17-39
Form 1 X1031

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..... *E. P. Kidwell*
Licensed Embalmer No..... *3877*
P. O. Address..... *6937^a Gravois*

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.