

Registration District No. \_\_\_\_\_

Primary Registration District No. 3036

State File No. \_\_\_\_\_

Registrar's No. 103

1. PLACE OF DEATH:

(a) County St. Charles  
(b) City or town St. Charles  
(c) Name of hospital or institution: St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME LORRAINE SCHROETER 636

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If \_\_\_\_\_

7. Birth date of deceased February 1st 1924  
(Month) (Day) (Year)

8. AGE: Years 16 Months 4 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Robertson MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name Mrs. Schroeter Jr.

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

14. Maiden name Verona Kaiser

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

16. (a) Informant's own signature Julius E. Rauch

(b) Address St. Charles, Mo.

17. (a) Burial (b) Date thereof June 11, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lutheran Cemetery

18. (a) Signature of funeral director Rasmann - Beer

(b) Address 326 N. 6th St - St. Charles MO

19. (a) 6/11/40 (b) Clarence B. Hessler  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. St. Ferdinand Township  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8  
year 1940 hour 11 minute 50 A.M.

21. I hereby certify that I attended the deceased from June 1, 1940, to June 8, 1940  
that I last saw her alive on June 8, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death: Plastic Anemia

Due to Cholerae mink novae

Due to \_\_\_\_\_

Other conditions: Varicella left

Major findings: Of operations none

Of autopsy varicella left  
Hemorrhage of kidneys and lungs

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?  
Yes (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

28. Signature B. J. Hessler (M. D. or other) M.D.

Address St. Charles, Mo. Date signed 6/10/40

Duration

10 days

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.

*Dr. Neubauer*

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**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 *Arthur C. Bane* .....

Licensed Embalmer No. *8144* .....

P. O. Address *St. Charles Mo.* .....

**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.**