

Registration District No. 791

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis, Missouri  
 (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 Sanitarium  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 yrs. 3 mos. 3 days  
(Specify whether  
 In this community 57 yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 13 #  
(If outside city or town limits, write "RURAL")  
 Street No. 6425 Dale Ave  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27th.  
 year 1940 hour 4:30 minute 8 M. A.  
 21. I hereby certify that I attended the deceased from 7-1-38  
 \_\_\_\_\_, 19\_\_\_\_, to July 27th., 19 40  
 that I last saw her alive on July 27th., 19 40  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
Chronic Myocarditis with  
Myocardial degeneration  
(onset 4-25-38)

Due to \_\_\_\_\_  
Senility (onset 4-25-38)

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy Yes

Duration \_\_\_\_\_  
 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)

(a) Signature of funeral director Beiderwieden Funl Home Inc While at work? \_\_\_\_\_  
 (b) Address 1936 Stc Louis Ave (e) Means of injury 1  
 23. Signature G. K. Bueck (M. D. or other) \_\_\_\_\_  
 Address 5800 ARSENAL Date signed 7/28/40

3. (a) PRINT FULL NAME Amelia Schmidt 530  
 (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 Widow

6. (b) Name of husband or wife Chas. Schmidt 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 11, 1866  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
About	<u>74</u>			hr. _____ min.

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

10. Usual occupation Housewife

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

12. Name Bernard Spiegel  
 13. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown  
 15. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Peter Smith  
 (b) Address 5400 Grand

17. (a) Burial (b) Date thereof July 30 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Beiderwieden Funl Home Inc  
 (b) Address 1936 Stc Louis Ave

19. (a) JUL 29 1940 (b) J. F. Bredick  
(Date received by registrar) (Registrar's signature)

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

**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 *Gene Hays*

Licensed Embalmer No. 2737

P. O. Address 1926 N. Young

**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.**