

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26710**
Registrar's No. **6606**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(c) Name of hospital or institution: **LUTHERAN HOSPITAL**
(d) Length of stay: **13 WEEKS**
In this community **27** years, months or days (Specify whether years, months or days) **ILL**

3. (c) PRINT FULL NAME **MINNIE LEONA SCHREIBER**
8. (b) If veteran, name war **no** 8. (c) Social Security No. **none**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**
6. (b) Name of husband or wife **Edwin H.** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **JUNE 17 - 1873**
(Month) (Day) (Year)

8. AGE: Years **67** Months **1** Days **15** If less than one day hr. min.

9. Birthplace **CHARLESTON Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **home**

12. Name **EDGAR PERRY**

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

14. Maiden name **Mick**

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

16. (a) Informant's own signature **Floyd Schreiber**

(b) Address **5423 Cologne**

17. (a) **Burial** (b) Date thereof **8/5/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St Matthews**

18. (a) Signature of funeral director **Henry J. Wisniewski**

(b) Address **6203 Gray**

19. (a) **AUG 3 1940** (b) **J. F. Prudeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St Louis**
(d) Street No. **5423 Cologne 2**
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **1st** year **1940** hour **7:15** minute **P** M.
21. I hereby certify that I attended the deceased from **April**, 19**40**, to **August**, 19**40**.
that I last saw her alive on **Aug 1st**, 19**40**.
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **4 Mo**
Due to **Arteriosclerosis** **yes**
Hypertension **"**
Due to **Diabetes Mellitus** **"**

Other conditions **Senility**
(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 **1**

23. Signature **Arnold E. Klein** (M. D. or other) **1**
Address **2632 S. Kingshighway** Date signed **8/2/40**

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.

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 Guy W. Wilkinson

Licensed Embalmer No. 3575

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.