

No. 2
-13-40
17-39
X23159

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7843**

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: St. Louis City Hospital #1, /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Mos., 16 Days
(Specify whether years, months or days)

In this community 75 Years

3. (a) PRINT FULL NAME August Paschedag

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Johanna Paschedag

6. (c) Age of husband or wife if alive years

7. Birth date of deceased April 4, 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>5</u>	<u>15</u>	hr. min.

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired City Fireman

11. Industry or business 6

12. Name August W. Paschedag

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

14. Maiden name Wilhelma Stinkemeier

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

16. (a) Informant Mrs. Clinda Brookham

(b) Address 4765 Greer Ave.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Sept. 21, 1940
(Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cem.

18. (a) Signature of funeral director Wm. Paschedag

(b) Address 2825 N. Grand Blvd.

19. (a) SEP 20 1940
(Date received at registrar's office)

(b) [Signature]
(Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 4765 Greer Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 18,
year 1940 hour 11:30 minute _____ P. _____ M.

21. I hereby certify that I attended the deceased from March
2, 1940, to September 18, 1940;
that I last saw him alive on September 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Prostate

Due to 51

Due to Hypertension

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature Walter Ford (M. D. or other) _____

Address 1515 Lafayette Ave., Date signed 9/19/40

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

MOTHER FATHER

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.....

3570

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, fact should be so stated above.