

0. 2  
13-40  
7-39  
X29159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34108  
Registrar's No. 8805

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

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: 5022 Dewey  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME William Schaelich

3. (b) If veteran, name war none  
3. (c) Social Security No. 192-05-2863

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Mar.

(b) Name of husband or wife Gertrude Schaelich 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased 9-28-1886  
(Month) (Day) (Year)

8. AGE: Years 54 Months 0 Days 26 If less than one day hr. min.

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

10. Usual occupation Manager

11. Industry or business Foundry

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Wm Schaelich

(b) Address 5022 Dewey

17. (a) Burial (b) Date thereof 10-26-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Southwestern Funeral Home

(b) Address 6322 S Grand

19. (a) OCT 25 1940 (b) J. B. Budick  
(Date certified) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
(c) City or town St. Louis 15  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5022 Dewey  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24th  
year 1940 hour \_\_\_\_\_ minute 6:30 P. M.

21. I hereby certify that I attended the deceased from Oct 20  
1938 to Oct 24 1940  
that I last saw him alive on Oct 22 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Tubercular Heart Disease 27%

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

Other conditions: Henipke's duck 27%  
(Include pregnancy within 3 months of death)  
Cerebral aneurysm

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

Duration 27%  
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) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Wm Hegerman (M. D. or other)  
Address 2924 S Grand Date signed 10/25/40

Dr Eyerman  
292 4 S. Grand

---

---

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.....

*Frank Ludwig*

Licensed Embalmer No. *2504*

P. O. Address *St Louis*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**