

FILED MAY 13 1941

Registration District No. 791

Primary Registration District No. 1003

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

Registrar's No. 3337

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(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 8 Days  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Herman Schoor

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Ella Schoor

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

7. Birth date of deceased: Jan 28 1863  
(Month) (Day) (Year)

8. AGE: Years 78 Months 2 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired Saloon Keeper

11. Industry or business Own

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 Ed. Schoor

(b) Address 5002 Idaho, St. Louis

17. (a) Burial (b) Date thereof Apr. 18, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director Baberman Bros.

(b) Address 2504 Woodson, Overland Mo.

19. (a) APR 17 1941 (Date received local registrar)  
J. W. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 00016

(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")

(d) Street No. 3419 Hartford 9  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15 year 1941 hour 10:15 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from April 8, 1941 to April 15, 1941:  
that I last saw him alive on April 15, 1941:  
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of pharynx & metastasis to the neck.

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

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

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

Of autopsy: No.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Robert E. Koch (M. D. or other) \_\_\_\_\_

Address 1515 Lafayette Avenue Date signed 4/16/41

**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..... *Oscar A. Mueller* .....

Licensed Embalmer No. *3039* .....

P. O. Address *2517 Woodrow Overland* .....

**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.**