

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **5012**

1. PLACE OF DEATH:

(a) County **ST LOUIS**

(b) City or town **ST LOUIS**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **6917 GARNER AV = 1**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **100**

(c) City or town **ST LOUIS** **417**  
(If outside city or town limits, write "RURAL")

(d) Street No. **6917 GARNER AV = 9**  
(If rural, give location)

(e) If foreign born, how long in U. S. A? **6** years.

3. (a) PRINT FULL NAME **ELIZABETH ANNA SCHAEFER**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex **FEMALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **HERMAN SCHAEFER =**

6. (c) Age of husband or wife if alive **8-1878** years  
(Month) (Day) (Year)

7. Birth date of deceased **AUG 8-1878**  
(Month) (Day) (Year)

8. AGE: Years **62** Months **10** Days **9** If less than one day \_\_\_\_\_  
hr. min.

9. Birthplace **ST LOUIS** **OMO =**  
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME =**

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

MOTHER FATHER { 12. Name **WILLIAM KIETH**

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

14. Maiden name **AUKIENNE WALTERS -**

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

16. (a) Informant \_\_\_\_\_

(b) Address **6917 GARNER AV -**

17. (a) **BURIAL** (b) Date thereof **6/20/41 -**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **NEW ST. PETER + PAUL CHURCH =**

18. (a) Signature of funeral director **M. J. Croghan**

(b) Address **7146 MANCHESTER AV =**

19. (a) **JUN 18 1941** (b) **J. F. Fredrick**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **17** year **1941 -** hour **9** minute **10 P.** M.

21. I hereby certify that I attended the deceased from **Jan. 18 '41** to **Jan. 17**, 19**41**, that I last saw **her** alive on **Jan. 17**, 19**41**, and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration \_\_\_\_\_

Due to **hypertension**

Due to **Nephritis + diabetes**

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

Major findings: Of operations **6/57**

Of autopsy \_\_\_\_\_

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 **Chas. Wolff** (M. D. or other) \_\_\_\_\_  
Address **7403 Manchester** Date signed **6/18/41**

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

00  
17  
9

**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

*Francis A. Williamson*

Licensed Embalmer No.

*3565*

P. O. Address

*7146 Manchester*

**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.**