

Registration District No. **791**

Primary Registration District No.

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:  
St. Anthony Hospital  
(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 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3932 Fairview Ave.  
(If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22  
 year 1941 hour 1 minute 55 p.m.

21. I hereby certify that I attended the deceased from June 13 1941 to June 22 1941;  
 that I last saw him alive on June 22 1941;  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Carcinoma of Stomach. Duration 6 weeks

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

Due to H/O

Other conditions Carcinoma of liver Duration 1 year  
(Include pregnancy within 7 months of death)

Major findings: Cancer of Stomach involving  
 Of operations two third of same  
 Of autopsy non

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 Julien Peter Ratter (M. D. or other) M.D.  
 Address 2603 Cherokee St Date signed 6/23/41

3. (a) PRINT FULL NAME Florian Schandl

3. (b) If veteran, name war --- 3. (c) Social Security No. 494-07-661

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

6. (b) Name of husband or wife Louisa 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased December 27, 1884  
(Month) (Day) (Year)

8. AGE:		Years	Months	Days	If less than one day
		<u>56</u>	<u>5</u>	<u>25</u>	hr. min.

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

10. Usual occupation Freight Handler

11. Industry or business Anheuser Busch Inc.

12. Name John Schandl

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

14. Maiden name Unknown

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

16. (a) Informant Louisa Schandl

(b) Address 3932 Fairview Ave.

17. (a) Burial (b) Date thereof 6/25/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation N. S. S. Peter & Paul

18. (a) Signature of funeral director Wacker-Pohlische

(b) Address 3634 Gravois Ave

19. (a) JUN 24 1941 (b) J. F. Bredbeck  
(Date received local registrar) (Registrar's signature)

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

1997

**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..... *Robert Wheeler*.....  
Licensed Embalmer No. *2128*  
P. O. Address *St Louis Mo*

**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.**