

V. S. No. 2  
OM--1-4-41  
v. 5-17-39  
X26390

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

FILED FEB 24 1942

Registration District No. 7911

Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis

(c) Name of hospital or institution: St. John's Hospital  
(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 St. Louis

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

(d) Street No. 5630 Milentz Ave.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lee R. Schaefer

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 3rd  
year 1942 hour 4 minute A.M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Margaret Schaefer

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased March 14th 1898  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-1 1942 to 1-3 1942

that I last saw him alive on 1-3 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured Esophageal varix

8. AGE:	Years	Months	Days	If less than one day
	<u>44</u>	<u>9</u>	<u>20</u>	hr. _____ min. _____

Due to Carbuncles of liver + Chronic gastritis of liver

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

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

Other conditions (Include pregnancy within 3 months of death) None

10. Usual occupation Patrolman  
Metropolitan Police Dept.

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

Of autopsy as above

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name John Schaefer

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

14. Maiden name Martha Morrow

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

16. (a) Informant Margaret Schaefer

(b) Address 5630 Milentz Ave.

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? \_\_\_\_\_

17. (a) Entombment (b) Date thereof 1-6-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Mausoleum

23. Signature Victor E. Schermer (M. D. or other) MD  
Address 508 W. Grand Date signed 1-5-42

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address 4228 So. Kingshighway Blvd.

19. (a) 1-3-42 (b) J. E. Brudeck  
(Date received local registrar) (Registrar's signature)

Dr. Victor Sherman

*Smetsky, Edg*

*12-2*

**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

*Edwin D. Mc Dermott*

Licensed Embalmer No. *3024*

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.**