

15571

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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

FILED MAY 11 1942

Primary Registration District No. 20

Registrar's No. 983

1. PLACE OF DEATH:

(a) County ST. LOUIS  
 (b) City or town Chesterfield  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
ST. LOUIS COUNTY 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 MISSOURI (b) County ST. LOUIS  
 (c) City or town CHESTERFIELD  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Rt. 1  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

8. (a) PRINT FULL NAME ROBERT SCHOENFELD

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased JAN 20 1942  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 3 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name EDWIN SCHOENFELD

18. Birthplace LONEDELL MO  
(City, town, or county) (State or foreign country)

14. Maiden name ROSE BAILEY

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

16. (a) Informant's own signature Jane Bailey

(b) Address Lone Dell Mo.

17. (a) BURIAL (b) Date thereof MAY 3 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Clair, Mo.

18. (a) Signature of funeral director Callahan

(b) Address St. Clair Mo

19. (a) MAY 2 - 1942 (b) C. J. McHann  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd  
year 1942 hour 2:30 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Failure

Due to Purulent Bronchitis

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

Other conditions (Include pregnancy within 3 months of death) 1061-

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

Of autopsy Purulent Bronchitis

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 John J. Matthews (M. D. or other) \_\_\_\_\_

Address St. Louis County Hosp Date signed 5/2/42

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

Rev. 5-17-39 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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.....

Licensed Embalmer No.....

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, above space should be left blank.**