

S. No. 2
1-1-4-41
5-17-39
P. I. X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16646

State File No. _____
Registrar's No. 5083

FILED JUN 22 1942 791
Registration District No. _____

Primary Registration District No. _____

00
17
9
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis, Mo
(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4001 Delmar
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 1 Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 17
(c) City or town St. Louis 919
(If outside city or town limits, write "RURAL")
(d) Street No. 4001 Delmar
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME VALENTINE E. SCHROEER

3. (b) If veteran, name war no
3. (c) Social Security No. 492-12-9999

4. Sex M Color or race O W
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Catherine
6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased. Feb 27 1868
(Month) (Day) (Year)

8. AGE: Years 74 Months 3 Days 11
If less than one day _____ hr. _____ min.

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

10. Usual occupation labor

11. Industry or business _____

12. Name William Schroer

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

14. Maiden name Beet

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

16. (a) Informant Mrs. Catherine Schriest
(b) Address 4001 Delmar

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

(c) Place: burial or cremation Laura Hill Garden
18. (a) Signature of funeral director E. Carl White
(b) Address 4259 Grand

19. (a) JUN 11 1942 (b) J. F. Medsker
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month 6-8 day _____
year 42 hour _____ minute 30 P.M.

21. I hereby certify that I attended the deceased from 6:00 am to 8:30 am
first to pronounce dead
and that death occurred on the date and hour stated above.
I saw no other living persons alive on 6-8-42 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of esophagus Duration 1 yr

Due to _____

Due to Ho

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Cancer of esophagus
Of operation reformed of carcinoma
Of autopsy of gland release to undersigned

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) _____ Means of injury _____

23. Signature Wayne D. Spira (M. D. or other M.D.)
Address 2739 N. Grand Date signed 6-9-42

(Licensed Embalmer's Statement on Reverse Side)

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 Arnold W. Schoene
Licensed Embalmer No. 3864
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.