S. No. 2
OM—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

26181

State File No. 2

FILED JUL 24 1943

Registration District No. 317

Primary Registration District No. 6067

Registrar's No. 1655

1. PLACE OF DEATH:

(a) County St Louis County

(b) City or town Manchester Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Manchester Nursing Home (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week (Specify whether

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 17

(c) City or town St Louis 9 (If outside city or town limits, write "RURAL")

(d) Street No. 3530 Michigan Av (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME JOHN J SCHOBEL

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

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

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

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

7. Birth date of deceased June (Month) 4 (Day) 1860 (Year)

8. AGE: Years 83 Months 1 Days 14 If less than one day ..... hr. ..... min.

9. Birthplace austria (City, town, or county) austria 4 (State or foreign country)

10. Usual occupation Baker

11. Industry or business Baker

FATHER
12. Name Unknown
13. Birthplace austria (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Albert Scholet

(b) Address 3530 Michigan Av

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery Colony Center

18. (a) Signature of funeral director John P Collins Bro

(b) Address 928 N Grand Blvd

19. (a) (Date received by Registrar) (b) C J McKenna MD (Registrar's signature)

JUL 20 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 18 year 43 hour 9 minute 15A M.

21. I hereby certify that I attended the deceased from 9-11-43 ....., 19...., to 9-18-43, 19....; that I last saw him alive on 9-16-43, 19....; and that death occurred on the date and hour stated above.

Immediate cause of death Chr. myocarditis & sudden failure

Due to .....

Due to .....

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

Major findings:
Of operations .....
Of autopsy .....

Duration

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature C H Denny (M.D. or other) MD

Address Creve Coeur, Mo Date signed 7-19-43

(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 Albert L. Stopper

Licensed Embalmer No. 1861

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.