

FILED JAN 3 1944

Registration District No. **1818**

Primary Registration District No. **1003**

Registrar's No. **1150**

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:
BARNES 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.....

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

(d) Street No. **4637 Sacramento Ave.**
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **John George Schramm**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **493-01-4137**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **19**
year **1943** hour **9** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **Dec 11**, 19**43**, to **Dec 19**, 19**43**
that I last saw **him** alive on **Dec 19**, 19**43**
and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or race **W**

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

6. (b) Name of husband or wife **Anna Maibes Schramm**

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

7. Birth date of deceased **August 27 1881**
(Month) (Day) (Year)

Immediate cause of death **Multiple infarcts of lungs** Duration

Due to.....

Due to.....

8. AGE: Years Months Days If less than one day

62 3 22 hr. min.

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

10. Usual occupation **Press Feeder**

Other conditions **Bronchopneumonia, arteriosclerotic, chronic passive congestion of liver & spleen.**

Major findings: **As above**

Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business.....

12. Name **Unknown**

13. Birthplace **9**
(City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ann Schramm**

(b) Address **4637 Sacramento Ave.**

17. (a) **Burial** (b) Date thereof **12-22-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **SS Peter & Paul**

18. (a) Signature of funeral director **Stroot-Carroll**

(b) Address **4600 Natural Bridge Ave**

19. (a) **DEC 21 1943** (b) **J. Bredsch**
(Date received local registrar) (Registrar's signature)

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 **M. C. Abney** (M. D. or other)
Address **BARNES HOSPITAL** Date signed **12/20/43**

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

MOTHER FATHER

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

Frank H. Stroot

Licensed Embalmer No.

2265

P. O. Address

4609 N. Bridge Ave

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.