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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4456

State File No. _____

FILED FEB 7 1944
Registration District No. 377

Primary Registration District No. 3069

Registrar's No. 288

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary'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) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 412 Union Blvd. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John William Schaefer

3. (b) If veteran, name war No. _____ 3. (c) Social Security No. 189-09-5722

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 Sept. 15, 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 4 16 _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Mgr. St. Louis Hotel Supply Co

12. Name Louis Schaefer

13. Birthplace Kirtorf, Germany (City, town, or county) (State or foreign country)

14. Maiden name Bertha Dierberger (City, town, or county) (State or foreign country)

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

16. (a) Informant Lula Schaefer

(b) Address 412 North Union Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address 412 N. Union Blvd.

19. (a) FEB 3-1944 (Date received local registrar) (b) C. G. Mc Gowan, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 31 year 1944 hour 8 minute 44 P.M.
21. I hereby certify that I attended the deceased from Jan 26/44 to January 31, 1944 that I last saw him alive on January 31, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Thrombosis of Cerebral artery

Due to Arterial Sclerosis

Due to _____

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

Major findings: Of operations _____ Of autopsy Confirmed diagnosis

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) (e) Means of injury _____

23. Signature [Signature] (M. D. 2255222)

Address 3206 Lafayette Ave. Date signed 2/1/44

MAKES PERMANENT COPY ON PADDING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

MAY 24 1944

APR 24 1944

APR 18 1944

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, fact should be so stated above.