S. No. 2
M—2-43
. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13315

FILED APR 20 1944

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 3416

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

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: Little Sisters Of The Poor
(If not in hospital or institution, write street number or location)
3225 N. Florissant
(d) Length of stay: In hospital or institution 6 Years (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St Louis 1-20
(If outside city or town limits, write "RURAL")
(d) Street No. Little Sisters Of The Poor
3225 N. Florissant (Street or location)
(e) Citizen of foreign country? ~~22 D & Hebert~~ (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Joseph Schmidt

3. (b) If veteran, name war ..... 3. (c) Social Security No. None

4. Sex Male 0 | 5. Color or race White | 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Barbara Schmidt 6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased March 8 Th1870 (Month) (Day) (Year)

8. AGE: Years 74 ----- Months 1 -- Days 3 -- If less than one day ..... hr. ..... min.

9. Birthplace Bellgrad Jogo Schlavia (City, town, or county) (State or foreign country)

10. Usual occupation Retired Labarer

11. Industry or business .....

FATHER
12. Name Joseph Schmidt
13. Birthplace Bellgrad Jugo Schlavia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Not Knowen
15. Birthplace BellgradJugo Schlavia (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Anna Wolf
(b) Address 5517 Beacon Ave 1944

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14 Th (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Edw Koch
(b) Address 3514 N 14 Th Str

19. (a) APR 12 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11th year 1944 hour 5 minute 7 M.

21. I hereby certify that I attended the deceased from November 12, 1943 to April 11, 1944 that I last saw him alive on April 11, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardio-vascular renal Disease	??
Due to	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

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) None
(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 Bernard G. Stoffer (M. D. or other)
Address 2302 Salisbury St Date signed 4-12-44

(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 John Ketter

Licensed Embalmer No. 3880

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.