

FILED NOV 15 1944  
 918

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

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

1. PLACE OF DEATH:  
 (a) County \_\_\_\_\_  
 (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:  
Firmin Desloge Hospital  
 (If not in hospital or institution, write street number and location)  
 (d) Length of stay: In hospital or institution 7 Days  
 In this community 47 years  
 years, months or days

3. (a) PRINT FULL NAME Frank Schaefer  
 (b) If veteran, name war none  
 (c) Social Security No. none

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Marr.  
 (b) Name of husband or wife Mary Schaefer  
 (c) Age of husband or wife if alive 54 years  
 7. Birth date of deceased Mar. 23-1887  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
57 7 13 hr. min.

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

10. Usual occupation Structural Worker

11. Industry or business \_\_\_\_\_

12. Name Wm Schaefer

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

14. Maiden name Fanning Lane

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

16. (a) Informant Ms Mary Schaefer

(b) Address 25 29 Maiden Lane

17. (a) Burial (b) Date thereof 11-10-44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles

18. (a) Signature of funeral director J. J. Bredeck

(b) Address 2223 St. Louis Ave  
NOV 8 1944  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2529 Maiden Lane  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11-6-44 day \_\_\_\_\_  
 year \_\_\_\_\_ hour 9:25 p.m. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 10-31-44, 19\_\_\_\_, to 11-6-44, 19\_\_\_\_;  
 that I last saw him alive on 11-6-44, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute cardiac failure  
Duagon 6 days

Due to Hypertensive Cordis Vascula disease ?  
Atherosclerotic hardening ?

Due to Coronary Artery Disease ?

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_

Of autopsy were  
 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? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Rose P. Carney (M. D. or other) \_\_\_\_\_  
 Address Firmin Desloge Hospital Date signed 11-7-44

**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 P. Buchholz*

Licensed Embalmer No. *1674*

P. O. Address. *2229 St. Louis 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.**