

0-2  
5-43  
7-39  
X36671

FILED FEB 7 1945  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 918

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Louis City Hospital-Mex C. Starloff  
(If not in hospital or institution, write street number or location) Memorial

(d) Length of stay: In hospital or institution 14 days  
(Specify whether  
In this community 0  
years, months or days)

3. (a) PRINT FULL NAME Henry J. Schank

3. (b) If veteran, name war.....

3. (c) Social Security No. None

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: Aug 1918 2 1874  
(Month) (Day) (Year)

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

70 5 27 hr. min.

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

10. Usual occupation City of St. Louis

11. Industry or business Park Dept.

MOTHER FATHER

12. Name Henry Schank

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

14. Maiden name Carrie Zang

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

16. (a) Informant Mrs Carrie Cronenbold

(b) Address 4950 Columbia Ave

17. (a) Burial (b) Date thereof Jan 30 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Matthews Cem

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

(b) Address 1905 South Grand Blvd

19. (a) JAN 30 1945 (b) J. F. Brudeck  
(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")  
Street No. 1405 Hampton  
(If rural, give location)

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

000  
17  
49

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29th  
year 1945 hour 1:45 minute A. M.

21. I hereby certify that I attended the deceased from 1/15/45  
....., 19....., to 1/29/45, 19.....;

that I last saw h. im alive on 1/29/45, 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pemphigus Duration.....

Due to.....

Due to 153.2

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

Major findings:  
-Of operations.....

Of autopsy refused

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 J. F. Brudeck (M. D. or other) 172945  
Address 1515 Lafayette Date signed.....

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

---

---

**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..... *St Louis mo*

**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.**