No. 2
-5-43
-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 31 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 729

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 504

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:
4167 Wyoming St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 65 Years In St Louis
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. 1895 S. 14th St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ANNA SCHEJBAL(SCHEYBLE)

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Mathew Schejbal
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug. 4th 1866 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
78	5	12	hr. min.

9. Birthplace Bohemia (City, town, or county) 4 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business At Home

FATHER
12. Name William Kunbera
13. Birthplace Austria (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Katherine Andrle
15. Birthplace Bohemia (City, town, or county) 8 (State or foreign country)

16. (a) Informant Joseph Schejbal
(b) Address 4167 Wyoming St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19/45 (Month) (Day) (Year)
(c) Place: burial or cremation Old S.S. Peter & Paul
18. (a) Signature of funeral director Thos Kittis & Son
(b) Address 2906 Travois Ave
19. (a) JAN 17 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16
year 1945 hour 4 30 P.M. M.

21. I hereby certify that I attended the deceased from Jan 12, 1945, 19, to Jan 16, 1945
that I last saw h alive on Jan 16, 1945, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Left side paralysis

Due to

Due to

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

Major findings:
Of operations —
Of autopsy —

Duration

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 A. F. Plag (M. D. or other)
Address 3150 Morganford Rd Date signed 1/17/45

(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 David Van Fossan.

Licensed Embalmer No. 4242

P. O. Address 2906 Harris 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.