

Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **2667**

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
137 E. Cartwright
(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)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County St. Louis
 (c) City or town Lemay
(If outside city or town limits, write "RURAL")
 (d) Street No. 137 E. Cartwright
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Anna C. Schaefer
 3. (b) If veteran, name war No 3. (c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 23
 year 1944 hour 10 minute 40 P.M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Anton 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 4 1867
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 2, 44 to Dec. 23, 1944
 that I last saw him alive on Dec. 21, 1944 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>5</u>	<u>19</u>	hr. _____ min. _____

Immediate cause of death Diabetes mellitus
 Duration 10 yrs.

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

Due to _____
 Due to _____

10. Usual occupation Nil.

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

11. Industry or business _____
MOTHER FATHER
 12. Name Bernard Goehr
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Marie Wiling
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Mary Zurbriggen
 (b) Address 137 E. Cartwright
 17. (a) Burial (b) Date thereof 12-27-44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation New SS. Peter & Paul

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? _____

18. (a) Signature of funeral director J. P. Rindler Jr.
 (b) Address 7128 Michigan Ave.
 19. (a) DEC 27 1944 (b) E. J. McGowan
(Date received local registrar) (Registrar's signature)

While at work _____ (Specify type of place)
 (e) Means of injury _____
 Signature [Signature] M. D. or other _____
 Address 7707 Date signed 1/20/45

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

6000

7702 IVORY
10 am - 1 pm

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 *Edgar P. Schaubert*

Licensed Embalmer No. 3906

P. O. Address 7128 Mission

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.