

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 16 1945

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 2707

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Normandy Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Vincent's Sanitarium
(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 Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. R. F. D. #2
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 18
year 1944 hour 2:00 minute A M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Incised wound of the neck and left arm.

Duration

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy No.

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) Suicide.
(b) Date of occurrence Dec. 17, 1944
(c) Where did injury occur? St. Vincent's Sanitarium
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Sanitarium
(Specify type of place)

While at work? _____ Means of injury _____

Signature Arnold J. Willmann
Address Clayton Date signed 12-19-44

3. (a) PRINT FULL NAME Elva Schoen

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 Married

6. (b) Name of husband or wife Charles (c) Age of husband or wife if alive 61 years

7. Birth date of deceased April 9 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 8 8 _____ hr. _____ min.

9. Birthplace Dekalb County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Henry Foster

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

14. Maiden name Gertrude LaFallett

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

16. (a) Informant Chas. Schoen

(b) Address Rt. 2, St. Joseph, Mo.

17. (a) Removal (b) Date thereof 12-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) DEC 26 1944 (b) E. H. McLaughlin
(Date received local registrar) (Registrar's signature)

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

600

DEC 20 1948

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 Albert S. Hoffa.....

Licensed Embalmer No. 2971.....

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.