

S. No. 2
OM-5-43
v. 5-17-39
I X36671

15554

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **4853**

FILED JUN 9 1945
318

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
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Deaconess Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ (Specify whether _____)
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
 (c) City or town Berger
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) NR
 (e) Citizen of foreign country? 1 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Andreas C. Scheible
3. (b) If veteran, name war Nil
3. (c) Social Security No. N one

4. Sex Male **5. Color or race** White
6. (a) Single, widowed, married, Married
6. (b) Name of husband or wife Emily Scheible
6. (c) Age of husband or wife if 67 years
7. Birth date of deceased January 1 1877
 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>68</u>	<u>4</u>	<u>28</u>	hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name John C. Scheible
13. Birthplace Unknown Germany
 (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ruebling
(b) Address 7128 Kingsbury

17. (a) Burial (b) Date thereof 6-2-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Berger, Missouri

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

(b) Address 4700 Washington Blvd.

19. (a) Date received MAY 21 1945 **(b) Registrar's signature** J. F. Biedeck

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
 year 1945 hour 12:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from May 27 1945 to May 29 1945
 that I last saw him alive on May 29 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Sanguine Right Leg.
 Due to Thrombosis of Popliteal Artery
 Due to Auricular fibrillation from Chronic Myocarditis
 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 J. F. Biedeck (M. D. or other) _____
Address 607 N Grand **Date signed** 6-31-45

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 Agoncello*
Licensed Embalmer No. *2398*
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.