S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 7 1945

Registration District No. 317

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18252

Primary Registration District No. 2002

Registrar's No. 1165

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
6700 Raymond Ave.
(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 St. Louis 96

(c) City or town University City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 6700 Raymond Ave. 5
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME John J. Schaub

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Margaret Schaub

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased November (Month) 9 (Day) 1855 (Year)

8. AGE:

Years	Months	Days	If less than one day
89	6	9	..... hr. ..... min.

9. Birthplace Unknown (City, town, or county) Germany (State or foreign country) 11

10. Usual occupation Retired Carpenter 1

11. Industry or business .....

FATHER
12. Name Henry Schaub
13. Birthplace Unknown (City, town, or county) Germany (State or foreign country) 4

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 7

16. (a) Informant Mrs. Leona Dyer

(b) Address 5516 Maple Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-45 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

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

(b) Address 4700 Washington Blvd.

19. (a) MAY 21 1945 (Date received local registrar) E. C. G. [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1945 hour 5 minute 20 A.M.

21. I hereby certify that I attended the deceased from Death without medical attendance, 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 Coronary occlusion

Due to 94a

Due to .....

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

Major findings:
Of operations .....

Of autopsy No 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 0

23. Signature [signature] M.D. (M. D. or other)

Address 601 Brentwood Blvd. Date signed 5/19/45

(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 Albert G. Hoppe

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.