V. S. No. 2
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ev. 5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 19 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19173

Primary Registration District No. 1003

Registrar's No. 5040

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: ST. JOHN'S HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 DYS. (Specify whether
In this community 20 YRS.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 17
(c) City or town ST. LOUIS 620
(If outside city or town limits, write "RURAL")
(d) Street No. 2345 A. MADISON STR
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country NONE

3. (a) PRINT FULL NAME CHARLES SCHAFFNER.

3. (b) If veteran, name war NO.

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife SOPHIA.

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

7. Birth date of deceased SEPT (Month) 5TH (Day) 1878 (Year)

8. AGE: Years 66 Months 9 Days 1. If less than one day — hr. — min.

9. Birthplace NEW DOUGLAS (City, town, or county) ILL. (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business GEN. LABOR

FATHER
12. Name UNKNOWN.
13. Birthplace GERMANY (City, town, or county) (State or foreign country)

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

16. (a) Informant Margaret Garvey
(b) Address 2345a Madison St

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 9- 45 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director Brockland Und. Co.
(b) Address 1827 HOGAN STR.

19. (a) JUN 7 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6
year 45 hour 5 minute a M.

21. I hereby certify that I attended the deceased from May 1, 1945, to June 5, 1945
that I last saw him alive on 6/5, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to — 94a

Due to

Other conditions Vesical Calculus
(Include pregnancy within 3 months of death)

Major findings:
Of operations Lithola paxy
Lithola paxy
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 Leo Bartel (M. D. or other)
Address 313 U. F. Ch. Date signed 6/6/45

(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. G W Wilkinson

Licensed Embalmer No. 3575

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.