

19184 ✓
M-5-43
7-5-17-39
P 1 X38671

FEB JUN 30 1945 318

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **5286**

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. Louis City Hospital**
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **8 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **5537 Davidson**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Lillian Schowe**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Female** / 5. Color or race **Whitle**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Stephen Schowe**

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

7. Birth date of deceased **August 4, 1890**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	54	10	9	hr. min.

9. Birthplace **Unknown Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home**

11. Industry or business

12. Name **Bernard Buster**

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

14. Maiden name **Unknown**

15. Birthplace **Unknown Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Viola Miller**

(b) Address **5537 Davison Ave**

17. (a) Burial **(Burial, cremation, or removal)** **(b) Date thereof** **6/18/45**
(Month) (Day) (Year)

(c) Place: burial or cremation **Friedens Cemetery**

18. (a) Signature of funeral director **Math Hermann & Son**

(b) Address **2161 East Fair Ave**

19. (a) JUN 15 1945 **(b) J. J. Bredest**
(Date received for registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **13**
year **1945** hour **10:45** minute **P** M.

21. I hereby certify that I attended the deceased from **June**
6, 19 **45**, **June 13**, 19 **45**
that I last saw her alive on **June 13**, 19 **45**
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration

Arteriosclerotic & Hypertensive Cardiovascular disease

Due to **Pulmonary infarction**

Due to **Myocardial thrombosis, both auricles**

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

Major findings: _____

Of operations _____

Of autopsy **Same**

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **Carroll Hendrix** M. D. or other

Address **1515 Lafayette Avenue** **Date signed** **6/14/45**

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

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 William G. Burkholz
Licensed Embalmer No. 2110
P. O. Address St. Louis Mo

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.