V. S. No. 2
00M—5-43
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 1 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

#9 State File No. 21388

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1122

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Rural - Gravois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 9161 Coral Dr. Affton Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 9161 Coral Dr.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Caroline Schlueter
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 Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March 25, 1870 (Month) (Day) (Year)
8. AGE: Years 75 Months 1 Days 17 If less than one day hr. min.
9. Birthplace Europe (City, town, or county) (State or foreign country)
10. Usual occupation At home
11. Industry or business
MOTHER FATHER
12. Name ------- Fehrenbach
13. Birthplace Europe (City, town, or county) (State or foreign country)
14. Maiden name Not known
15. Birthplace Europe (City, town, or county) (State or foreign country)
16. (a) Informant Angeline Schlueter
(b) Address 9161 Coral Dr. Affton Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (Month) (Day) (Year)
(c) Place: burial or cremation N. St. Marcus Cem.
18. (a) Signature of funeral director J. L. Ziegenhein & Sons
(b) Address 7027 Gravois Ave.
19. (a) 5-14-45 (Date received local registrar) (b) E. B. McCausland (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12th year 1945 hour 1 minute A. M.
21. I hereby certify that I attended the deceased from May 9, 1945, 19..., to May 12, 1945, that I last saw her alive on May 12, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Intestinal obstruction	3 days
Hemorrhage from Gastro-intestinal tract (Vomitus only)	
Due to Cerebral Hemorrhage	1 day
Due to Hypertension	
122 b	

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None
Of autopsy None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(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 Leroy E. Ellison MD (M. D. or other) MD.
Address 3610 So Broadway Date signed 5-14-1945

(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 Sheldon Collier

Licensed Embalmer No. 3382

P.O. Address: 7077 Gravois

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.