

FILED AUG 3 1945  
Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 6635

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: City Hospital  
Max C. Starkloff Memorial 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 92 days  
(Specify whether  
In this community .....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 061  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 8205 Virginia 9  
(If rural, give location)  
(e) Citizen of foreign country? No 0 (Yes or No)  
If yes, name country .....

3. (a) PRINT FULL NAME HERMAN SCHIERHOFF

3. (b) If veteran, name war. No. No  
3. (c) Social Security No. No

4. Sex Male 0 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 May 3 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
83 2 17 hr. min.

9. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business .....

12. Name John Schierhoff

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Anna Hedeker

15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. N. Paquet

(b) Address Route 11 Lemay, Mo.

17. (a) Burial (b) Date thereof July 20, 45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Assumption Cem.

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.

(b) Address 7814 S. Broadway

19. (a) JUL 29 1945 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26  
year 1945 hour 3:30 minute P M.

21. I hereby certify that I attended the deceased from April  
26, 1945, to July 26, 1945.

that I last saw him alive on July 26, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis -  
Sen. Atherosclerosis Duration

Due to .....

Due to .....

Other conditions 83  
(Include pregnancy within 3 months of death)

Major findings: Of operations .....

Of autopsy .....

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) .....

23. Signature Haber C. Fritz (M. D. or other) .....

Address 1515 Lafayette Avenue Date signed 7/26/45

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

MOTHER FATHER

**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 Harry J. Schumacher  
Licensed Embalmer No. 2679  
P. O. Address 7814 S. Broadway

**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.**