. S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25097

FILED JUL 16 1945

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 1735

1. PLACE OF DEATH:

(a) County St. Louis Co.

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

(c) Name of hospital or institution: St. Louis Co. Hosp. O (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7-2-45 to 7-7-45 (Specify whether

In this community 45 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis Co.

(c) City or town Creve Coeur (If outside city or town limits, write "RURAL")

(d) Street No. Route # 2 (If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME FRED SCHIFFMANN

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife none

6. (c) Age of husband or wife if alive none years

7. Birth date of deceased 12 (Month) 25 (Day) 74 (Year)

8. AGE: Years 70 | Months 6 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Lebanon, (City, town, or county) Illinois (State or foreign country)

10. Usual occupation none

11. Industry or business none

FATHER
12. Name ?, Schiffmann
13. Birthplace unknown (City, town, or county) unknown (State or foreign country)

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

16. (a) Informant Mabel Rose (niece)

(b) Address 9503 Tennyson, Overland, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-45 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Zion Cem

18. (a) Signature of funeral director Ostmann Funeral Home

(b) Address 9222 Lockland Overland Mo

19. (a) 7-9-45 (Date received local registrar) (b) E. A. McGavran MD (Registrar's signature) MSA

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 7 day 7 year 1945 hour 12 minute 05 P.M.

21. I hereby certify that I attended the deceased from 7-2, 1945, to 7-7, 1945 that I last saw him alive on 7-7, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Acute Monocytic Leukemia

Due to Gangrenous Stomatitis

Due to 74a

Other conditions Arteria Sclerotic Heart disease (Include pregnancy within 3 months of death)

Major findings:
Of operations .....
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 Aaron Hendin (M. D. ~~or other~~)

Address St. Louis County Hosp. Date signed 7-7-45

(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.....Al C Ortmann.....

Licensed Embalmer No. 3478.....

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.