S. No. 2
M—2-43
5-17-39
P 1 X 5000

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 1 1945 318

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26113

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 7123

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

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Anthony's 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 8 hours (Specify whether years, months or days)
In this community: —

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Louis 96
(c) City or town: ~~4607 Oldenburg~~ 0
(If outside city or town limits, write "RURAL")
(d) Street No.: 4607 Oldenburg NR 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: Baby Schroeder
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: Baby 0
6. (b) Name of husband or wife: —
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: Aug. (Month) 26 (Day) 1945 (Year)

8. AGE: Years —, Months —, Days —, If less than one day: 8 hr. _____ min.

9. Birthplace: St. Louis (City, town, or county) 0 (State or foreign country)
10. Usual occupation: Baby
11. Industry or business: —
MOTHER FATHER
12. Name: Paul Walter Schroeder
13. Birthplace: St. Louis (City, town, or county) Mo. (State or foreign country)
14. Maiden name: Bernice Sommers
15. Birthplace: St. Louis (City, town, or county) Mo. (State or foreign country)
16. (a) Informant: Mrs. J. Sommers
(b) Address: 4607 Oldenburg
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 27 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Peter & Paul Cem.
18. (a) Signature of funeral director: Mitt Bros. L & U. Co
(b) Address: 2929 S. Jefferson
19. (a) AUG 27 1945 (Date received local registrar) (b) J. F. Roedick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug. day: 26 year: 1945 hour: 11 AM minute: _____ M.
21. I hereby certify that I attended the deceased from Aug. 26, 45, 19____, to Aug. 26, 1945, that I last saw h. alive on Aug. 26, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: a. Myocarditis	6 hr
(2) Premature new	9 days
Due to: 159	
Due to:	
Other conditions: Deformed of none (Include pregnancy within 3 months of death) Bilateral cleft palate	
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? (Specify type of place)
While at work? — (e) Means of injury: —
23. Signature: Louis J. Greenberg (M. D. or other)
Address: 748 Lemay Ferry Rd. Date signed: 8/27/45

(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.....

Licensed Embalmer No.....

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.