S. No. 2
0M—2-43
v. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

35177

State File No.

FILED NOV 23 1945

Registration District No.

Primary Registration District No. 1003

Registrar's No. 9794

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1510 Mallinckrodt /
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000

(c) City or town St Louis 1726
(If outside city or town limits, write "RURAL")

(d) Street No. 1510 Malinckrodt 4
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Elizabeth Deiss

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Michael Deiss

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

7. Birth date of deceased August (Month) 31st (Day) 1875 (Year)

8. AGE: Years 70 ------- Months 2--- Days 11-- If less than one day hr. min.

9. Birthplace St Louis (City, town, or county) 0 (State or foreign country)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Henry B Schomacher
13. Birthplace Germany (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Angela Schomacher
15. Birthplace Germany (City, town, or county) 4 (State or foreign country)

16. (a) Informant

(b) Address 3516 N 14 Th Str 1945

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov (Month) 15 (Day) Th (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Edward Koch

(b) Address 3516 N 14 Th Str

19. (a) NOV 1? 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 11
year 1945 hour 10 minute 00 P M.

21. I hereby certify that I attended the deceased from Sept 4, 1945, to Nov 11, 1945
that I last saw her alive on Nov 10, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other conditions Arteriosclerosis
(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 A. A. Hild (M. D. or other)

Address 3901 W Florissant Date signed 11/12/45

(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 John Kettler

Licensed Embalmer No. 3880

P. O. Address Ottawa, 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.