

FILED DEC 12 1945

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 180

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

1. PLACE OF DEATH:

(a) County St. Charles

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

(c) Name of hospital or institution:
128 Houston Street
(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

3. (a) PRINT FULL NAME Mrs. Wilhelmina Schroeder

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Theodore Schroeder

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased: January 2, 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68	10	22	hr. min.
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9. Birthplace: St. Charles County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Herman Meyer

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

14. Maiden name Fredericka Hallemeier

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

16. (a) Informant Theodore Schroeder

(b) Address St. Charles, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 27, 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Lutheran Cemetery

18. (a) Signature of funeral director Halkmann - Paul

(b) Address 326 N. 6th, Str., St. Charles, Mo.

19. (a) Nov 27, 1945 (Date received local registrar) (b) Ermst. S. Paul (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles

(c) City or town St. Charles
(If outside city or town limits, write "RURAL")

(d) Street No. 128 Houston Street
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 24
year 1945 hour 9 minute - P.M.

21. I hereby certify that I attended the deceased from NOV 20
19 45 to NOV - 24 19 45
that I last saw her ER alive on NOV 24 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death:

CEREBRAL HEMORRHAGE 1 HR.

ARTERIO SCLEROSIS 4 YRS

HYPERTENSION 2 YRS

Other conditions: _____
(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 Galvin J. Lay (M. D. or other) M.D.

Address St. Charles, Mo. Date signed 11/27/45

1340

JAN 25 1950

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 12-11-45

OCT 3 1949

AUG 1 1945

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 Arthur C. Bane

Licensed Embalmer No. 3155

P. O. Address St Charles

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.