

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

871
State File No. _____
Registrar's No. 429

FILED JAN 25 1948
Registration District No. _____

Primary Registration District No. 1003

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:
2717 Greer Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 71 years (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County *Gas*
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2717 Greer Ave.
(If rural, give location) *90*
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Ida Schaefering
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 Fred Schaefering
6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased March 17 1874
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 12th
year 1946 hour 9:00 PM minute M.
21. I hereby certify that I attended the deceased from Jan 7, 1946 to Jan 12, 1946
that I last saw him alive on Jan 12, 1946
and that death occurred on the date and hour stated above.
Immediate cause of death Epithelioma of Forehead.
EPI THELIOMA

8. AGE: Years 71 Months 9 Days 25 If less than one day hr. min.

Due to _____
Due to _____ *53*

9. Birthplace St. Louis Mo. (1)
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

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

11. Industry or business Unknown
12. Name Unknown
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Erna Matthews
(b) Address 2818 Montgomery St.
17. (a) Burial (b) Date thereof 1-15-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Zions Cemetery
18. (a) Signature of funeral director Hy. Leidner U. Co.
(b) Address 2223 St. Louis Ave.
19. (a) JAN 15 1948 J. F. Bredet
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury _____
23. Signature *W. H. Lewis* (M. D. or other) *MD*
Address 2342 Ashcroft Ave Date signed 1/14/46

3061
WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

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 P. Buchholz*
Licensed Embalmer No. *1674*
P. O. Address *2223 St. Louis Ave*

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.