S. No. 2
OM—5-43
v. 5-17-39
I X36671

#21676

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 876

FILED FEB 7 1946

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 887

3066

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

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(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 Missouri (b) County

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

(d) Street No. 2306 S. 10th St.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME JOHN SCHEIBENDREIN

3. (b) If veteran, name war -

3. (c) Social Security No. -

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 23rd (Day) 1887 (Year)

8. AGE: Years 58 Months 10 Days 2 If less than one day hr. min.

9. Birthplace Austria (City, town, or county) 4 (State or foreign country)

10. Usual occupation Shoeworker

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs. John Jacobs 1

(b) Address 5100 Cologne Ave.

17. (a) cremation (Burial, cremation, or removal) (b) Date thereof 1-28-46 (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Witt Bros. U&L Co.

(b) Address 2929 S. Jefferson Av.

19. (a) JAN 28 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 25th year 1946 hour 8:40 minute P M.

21. I hereby certify that I attended the deceased from 1/14/46, 19, to 1/25/46, 19; that I last saw him alive on 1/25/46, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congestive Heart Failure	7 Mos.
Due to Rheumatic Heart Disease	40 yrs
Due to	
Other conditions Scoliosis (Include pregnancy within 3 months of death) 95	Life

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 John Sidenner M.D. (M.D. or other)

Address 1515 Lafayette 1/28/46 Date signed

(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 me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed F. M. Davis

Licensed Embalmer No. 3741

P. O. Address 2929 So Jefferson av

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.