

S. No. 2
OM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7892**
Registrar's No. **1643**

FILED MAR 1 1946

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
5327 Delor St
(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**
(If outside city or town limits, write "RURAL")

(d) Street No. **5327 Delor St**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Emma M Schafer**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Louis Schafer** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 20 1866**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
79	6	27	hr. _____ min.

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

10. Usual occupation **Housework**

11. Industry or business **at Home**

12. Name **John Theobald**

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

14. Maiden name **Elizabeth Heuser**

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

16. (a) Informant **Wm L Schafer**

(b) Address **5324 Delor St**

17. (a) **Burial** (b) Date thereof **12 20 46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **Kriegshauser**

(b) Address **4228 So. Kingshighway**

19. (a) **FEB 18 1946** **J. J. Brueck**
(Date received local Registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **17**
year **1946** hour **1.10PM** minute _____ M.

21. I hereby certify that I attended the deceased from **July 1945** to **Feb 17 1946**
that I last saw him alive on **Feb 14 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
chronic degenerative myocarditis

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

Duration **3 mo**

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 **J. J. Brueck** (M. D. or other) **me**
Address **529 n 9th** Date signed **2/18/46**

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

MOTHER FATHER

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 *Edwin P. M. Linnagan*

Licensed Embalmer No. *3024*

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.

Dr. J. Linnagan