

FILED JUN 6 1946

1003

Registration District No. Primary Registration District No.

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:
Park Lane Hospital
(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 Michael Schacher

3. (b) If veteran, Nil 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased April 27 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 0 28 hr. min.

9. Birthplace Lincoln County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business

12. Name Michael Schacher
13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)
14. Maiden name Unknown Brangardt
15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Fred Karrenboch

(b) Address Wentzeville, Mo.

17. (a) Burial (b) Date thereof 5-27-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Monroe, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAY 27 1946 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
(c) City or town Wentzeville
(If outside city or town limits, write "RURAL")
(d) Street No. NR.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25
year 1946 hour 7 minute 05 A.M.

21. I hereby certify that I attended the deceased from
MAY 21 1946 to MAY 24 1946
that I last saw him alive on MAY 24 1946
and that death occurred on the date and hour stated above.
Immediate cause of death Strangulated
Surg. Hernia Duration 2 days

Due to
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations No operation
Of autopsy None

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) (e) Means of injury

23. Signature John H. Haglund (M.D. or other)
Address Melopark Rd. Date signed 5/27/46

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.....

Licensed Embalmer No.....

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.