S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 30 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31324

Registration District No. 517 Primary Registration District No. 3069 Registrar's No. 1930

1. PLACE OF DEATH:

(a) County ST LOUIS

(b) City or town RICHMOND HTS MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST MARYS HOSP O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 WEEKS (Specify whether
In this community 10 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST LOUIS 96

(c) City or town RICHMOND HTS MO 8
(If outside city or town limits, write "RURAL")

(d) Street No. 1100 BELLEVUE AVE 3
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 8

If yes, name country

3. (a) PRINT FULL NAME SISTER CHARLES MARIE (CATHERINE SCHMALLE)

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex F 1

5. Color or race W

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 MAY (Month) 2 (Day) 1886 (Year)

8. AGE:

Years	Months	Days	If less than one day
60	5	11	hr. min.

9. Birthplace ST GENEVIEVE (City, town, or county) MO (State or foreign country)

10. Usual occupation SISTER IN RELIGION

11. Industry or business ST MARYS HOSP

FATHER
12. Name JOHN W SCHMALLE
13. Birthplace ST GENEVIEVE (City, town, or county) MO O (State or foreign country)

MOTHER
14. Maiden name JULIA WILL
15. Birthplace ST GENEVIEVE (City, town, or county) MO O (State or foreign country)

16. (a) Informant SISTERS OF ST MARY

(b) Address 1100 BELLEVUE AVE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 16-1946 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ OLD ST PETER + PAUL

18. (a) Signature of funeral director Watson Bookeage

(b) Address 6536 Olaston Rd

19. (a) 9-16-46 (Date received local registrar) (b) Ruth Fallen MD (Registrar's signature) RSC

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 13
year 1946 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from Sept. 8, 1946, to Sept 13, 1946 that I last saw her alive on Sept 13 1946, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Metastatic Carcinoma of lung

Due to Carcinoma of large bowel

Due to 46

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 [signature] (M. D. or other)

Address 6344 Grand Ave Date signed 9/16/46

(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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No. 4053

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.