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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 7 1947
Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 3670

State File No. 41,937
Registrar's No. 3623

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Webster Groves, MO.
(c) Name of hospital or institution: 1521 Belton
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Albert John Schreiner
3. (b) If veteran, name war No. 3. (c) Social Security No. 702-12-8904

4. Sex M. 5. Color or race W.
6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Alice Carroll Cushing
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased July 12 1884
(Month) (Day) (Year)

8. AGE: Years 62 Months 5 Days 16
If less than one day hr. min.

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

11. Industry or business S.W. Passenger Assn.
12. Name John Schreiner
13. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Kate Emmendorfer
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Alice Cushing Schreiner
(b) Address 1521 Belton
17. (a) burial (b) Date thereof 12-31-1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Alexander Sons
(b) Address 6175 Delmar
19. (a) 1-2-47 (b) Auth J Allen MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")
(d) Street No. 1521 Belton
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 28
year 1946 hour 10: minute 35 M.
21. I hereby certify that I attended the deceased from Nov 10 to Dec 28 1946
that I last saw him alive on Dec 28 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis
Due to 131A
Due to 131A
Other conditions Parotid - bronchial Parv
(Include pregnancy within 3 months of death) none

PHYSICIAN
Major findings:
Of operations none
Of autopsy none
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 U
23. Signature R J Vallon (M. D. or other) MD
Address 53 W. Big Bend Date signed 12/30/46

*Dr. C. J. Volleman
55 W. Bay Street Rd.
Hoboken 9203
Reg. Expires 2/28/48*

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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 *G. E. McCulloch*
Licensed Embalmer No. *2760*
P. O. Address *6175 Dilmar*

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.