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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 122

FILED APR 2 1947

Registration District No. 47

Primary Registration District No. 3008

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Hutton

(c) Name of hospital or institution: State Hospital # 12
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 6 m 15 d
(If not in hospital or institution, write street number or location)

In this community same
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis

(c) City or town Jenay (23)
(If outside city or town limits, write "RURAL")

(d) Street No. 743 Regina Ave
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EDWARD SCHAUENBERG

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28
year 1947 hour 2 minute 10 M.

21. I hereby certify that I attended the deceased from 3/24 1947 to 3/28 1947;
that I last saw him alive on 3/28 1947;
and that death occurred on the date and hour stated above.

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased June 17 1864
(Month) (Day) (Year)

Immediate cause of death Pneumonia terminal

Duration _____

8. AGE: Years 82 Months 9 Days 11
If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

10. Usual occupation Engineer

Other conditions leg amputated above knee 3/27/47
(Include pregnancy within 3 months of death)

11. Industry or business d/k

12. Name Albert Schauenberg

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

14. Maiden name d/k

15. Birthplace d/k
(City, town, or county) (State or foreign country)

Major findings: arterio sclerosis
Of operations _____

Of autopsy leg amputated above knee 3/22 same cause

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Hospital records

(b) Address Hutton Mo

17. (a) Removal (b) Date thereof 3-28-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Gouen Mc

18. (a) Signature of funeral director J. G. Caldwell

(b) Address 7420 Washington St

19. (a) 3-28-1947 (b) Josiah Monmouth
(Date received local registrar) (Registrar's signature)

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 Caldwell (M. D. or other) md
Address Hutton Mo Date signed 3/28/47

Date Filed 3-31-47

District File Number _____

District Health Officer No. 9,

RECEIVED

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 Oliver E. Fendler

Licensed Embalmer No. 4148

P. O. Address Long No

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.