S. No. 2
—12-45
5-17-39
P I X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11489

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2507

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1805 Prairie Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1805 Prairie Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Joseph Schade
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Theresa Peter
6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased June 8 1864 (Month) (Day) (Year)
8. AGE: Years 82 Months 8 Days 0 If less than one day hr. min.
9. Birthplace St. Louis, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name Bernard Schade
FATHER 13. Birthplace Germany (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Theresa Schade
(b) Address 1805 Prairie Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 11 '47 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Bromschwig and Son Funeral Home
(b) Address 4746 W. Florissant Ave.
19. (a) MAR (Date received by local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8 year 1947 hour 4:00 minute A. M.
21. I hereby certify that I attended the deceased from June 1946, to March 8 1947 that I last saw him alive on March 7 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Myocarditis	6 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Arteriosclerosis	15 yrs

Major findings: Of operations None
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) None
(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 0
23. Signature Thomas J. Harlan (M. D. or other) MD
Address 4500 Olive Date signed 7-9-47

(Licensed Embalmer's Statement on Reverse Side)

AUG 25 1954

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.....2575

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.