S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 24 1947
#69169

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11492

Registration District No. 318 Primary Registration District No. 1005 Registrar's No. 2744

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(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)

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. 4203 Walsh St.
Memorial (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME BERTHA SCHAFFNIT

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Husband Peter Schaffnit

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

7. Birth date of deceased January (Month) 20 (Day) 1863 (Year)

8. AGE: Years 84 Months 1 Days 21 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown Wieland
13. Birthplace Unknown (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Germany (State or foreign country)

16. (a) Informant Carl Schaffnit
(b) Address 5734 Delor

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (Month) (Day) (Year)
(c) Place: burial or cremation Bethany Cemetery

18. (a) Signature of funeral director Witt Bros. L & U. Co.
(b) Address 2929 S. Jefferson Ave.

19. (a) MAR 15 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13th year 1947 hour 6:00 minute P M.

21. I hereby certify that I attended the deceased from 3/11/47, 19, to 3/13/47, 19; that I last saw her alive on 3/13/47, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease — Duration 10 yrs

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 George R. Smith (M.D. or other)
Address 1515 Lafayette Date signed 3/14/47

(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.....

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.