

Registration District No. **317**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County **ST. LOUIS**
(b) City or town **BALLWIN**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
PINE CREST HOMES 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12/1/46** (Specify whether)
In this community **3/24/47**
years, months or days

3. (a) PRINT FULL NAME **JOHN SCHEIDEGGER**

3. (b) If veteran, name war 3. (c) Social Security No. **NONE**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **MARY SCHEIDEGGER** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **AUGUST 16 1863**
(Month) (Day) (Year)

8. AGE: Years **83** Months **7** Days **8** If less than one day hr. _____ min.

9. Birthplace **LITTLE BERGER MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **unknown 5**

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

14. Maiden name _____

15. Birthplace **unknown Switzerland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Gattlieb Haerer**

(b) Address **R.F.D. Herinain Mo**

17. (a) **Burial** (b) Date thereof **3-27-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ST. JOSEPH CEMETERY**

18. (a) Signature of funeral director **Hegon Blum**
(b) Address **Herinain Mo**

19. (a) **3-26-47** (b) **Ruth J. Allen Mo**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **GASCONADE**
(c) City or town **HERMANN (RURAL)** 37
(If outside city or town limits, write "RURAL")
(d) Street No. **10 MILES S. of HERMANN**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **24**
year **1947** hour **7:** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **Dec 1st** 19**46** to **March 24** 19**47**
that I last saw him alive on **March 23rd** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**
Duration _____

Due to _____
Due to _____

Other conditions **Chronic Interstitial Nephritis**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **1318**

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?

While at work? _____ (Specify type of place) (e) Means of injury **0**

23. Signature **R. W. Jansen** (M. D. or Other) _____
Address **Memphis Mo** Date signed **3/25/47**

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.....

Hugot Plume

Licensed Embalmer No. *3160*

P. O. Address..... *Herman*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. _____

1. PLACE OF DEATH: **ST. LOUIS**
 (a) County _____
 (b) City or town Ballwin
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (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)

3. (a) PRINT FULL NAME John Scheidegger
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married wid
 divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased aug 16 (Month) (Day) (Year)

8. AGE: 83 Years 83 Months 0 Days If less than one day
 hr. min.

9. Birthplace _____ (City, town or county) (State or foreign country) mo

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

{ 14. Maiden name _____

{ 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) 3-26-47 (Date received local Registrar) (b) Ruth J. Allen M.D. (Registrar's signature)

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

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month _____ Year 1947 Hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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) (c) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

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

