

No. 2
2-45
7-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 15623
Registrar's No. 4135

FILED MAY 1 1947

Registration District No. 318 Primary Registration District No.

1. PLACE OF DEATH:
(a) County MISSOURI
(b) City or town ST. LOUIS
(c) Name of hospital or institution: ST. ANTHONY'S HOSP.
(d) Length of stay: In hospital or institution 1 MONTH
In this community years, months or days

3. (a) PRINT FULL NAME ADA SCHMITT
3. (b) If veteran, name war. 3. (c) Social Security No.
4. Sex FEMALE 5. Color or race white
6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased AUG. 27-1872
(Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days 23
If less than one day hr. min.

9. Birthplace MO. (City, town, or county) (State or foreign country)
10. Usual occupation WIDOW

11. Industry or business AT HOME
12. Name PETER FRIEDRICHS
13. Birthplace GERMANY
14. Maiden name UNKNOWN
15. Birthplace GERMANY

16. (a) Informant KENNETH SCHMITT
(b) Address 3502 NEBRASKA

17. (a) BURIAL (b) Date thereof APR. 23, 1947
(c) Place: burial or cremation OLD S.S. PETER & PAUL

18. (a) Signature of funeral director Thomas Kulis & Son
(b) Address 2906 GRAVOIS

19. (a) ADD 5 (b) J. F. Bradock (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County
(c) City or town ST. LOUIS
(d) Street No. 3502 NEBRASKA D
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month APRIL day 20
year 1947 hour 12 minute NOON M.
21. I hereby certify that I attended the deceased from Nov 19 1947 to Apr 20 1947
that I last saw alive on Apr 20 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Pulmonary Embolism
Due to
Hb
Primary Carcinoma of Rectum
Other conditions
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Colostomy on 3/19-47
Of operations
Underline the cause to which death should be charged statistically.
Pulmonary Embolism
Ca of Rectum & Liver

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?

23. Signature of physician: Dept. L. Harris (M. D. or other)
Address: 4065 So. Grand Date signed: 4/21/47
While at work? (Specify type of place) (c) Means of injury

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

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..... *James C. Will*

Licensed Embalmer No. *4347*

P. O. Address. *2906 Lewis*

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.