

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15628
4513
Registrar's No. _____

Registration District No. 318 Primary Registration District No. 1003

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:
Mo. Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1-NO. 2 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Overland
(If outside city or town limits, write "RURAL")
(d) Street No. 920 1/2 - St. Charles Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Anna Scholle
3. (b) If veteran, name war None 3. (c) Social Security No. None
4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife William 6. (c) Age of husband or wife if alive 82 years
7. Birth date of deceased Feb 6 1873
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 1 year 1947 hour 8 minute 00 A. M.
21. I hereby certify that I attended the deceased from March 27, 1947, to May 1, 1947, that I last saw hER alive on May 1, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Chl. Myocarditis Duration 1 yr
Due to 186
Due to _____
Other conditions fracture of left femur 35 days
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
74 2 25 hr. _____ min.
9. Birthplace Florissant Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business _____
12. Name George Schroeder
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)
16. (a) Informant William Scholle
(b) Address 920 1/2 - St. Charles Rd - Overland, Mo.
17. (a) Burial (b) Date thereof 5-3-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lake Charles Park
18. (a) Signature of funeral director Maunary Brothers
(b) Address 250 1/2 - Woodson Rd - Overland - 14 - Mo.
19. (a) MAY 3 1947 (b) J. F. Bredeek
(Date received local registrar's certificate) (Registrar's signature)

Major findings: fracture of left femur
Of operations upper 1/3
Of autopsy W
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 3/27/47
(c) Where did injury occur? St. Louis County
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
(Specify type of place) (e) Means of injury 6 above
23. Signature Maurice A. Dehn (M. D. or other) MD
Address 8924 St. Charles Rd Date signed 5/2/47

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 Oscar F. Mueller

Licensed Embalmer No. 3039

P. O. Address Overland 14 Mo

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15628

Registration District No.

Primary Registration District No.

Registrar's No. 4513

1. PLACE OF DEATH:

(a) County..... St. Louis

(b) City or town..... St. Louis
(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 Anna Schelle

3. (b) If veteran, name war..... 3. (c) Social Security No.

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days (If less than one day) min.

77

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

10. Usual occupation.....

11. Industry or business.....

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) 4-19-48 (b) J. J. Bradest
(Date received local registrar) (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 May day 19 year 1947 hour 10 minute 00 M.

21. I hereby certify that I attended the deceased from 1947 to 1947, 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death.....

Duration.....

Due to Fall should appear on the record

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?.....
While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

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

MOTHER FATHER

15628