S. No. 2
M—2-43
. 5-17-39
-1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19332

State File No.

FILED JUN 13 1947

Registration District No. 1003

Primary Registration District No.

Registrar's No. 5577

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: Bethesda General
(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 20 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 818 Salisbury
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Alfred C. Schaaden

3. (b) If veteran, name war No

3. (c) Social Security No. 492-07-1470

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased 2 (Month) 19 (Day) 05 (Year)

8. AGE: Years 42 Months 3 Days 14 If less than one day hr. min.

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

10. Usual occupation Foreman

11. Industry or business International Paper Co

FATHER
12. Name John Schaaden
13. Birthplace Lebanon, Ill. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Anna Schandlagen
15. Birthplace Lebanon, Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Henry Schardan
(b) Address 7155 Idaho ave.

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof JUNE 7-47 (Month) (Day) (Year)
(c) Place: burial or cremation ST. JOHNS CEM COLLINSVILLE ILL

18. (a) Signature of funeral director C. Hoffmeister U.&L.Co.
(b) Address 7814 S. Broadway

19. (a) JUN 5 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 3 year 47 hour 5 minute 10 a M.

21. I hereby certify that I attended the deceased from April 26, 1947, to June 3, 1947, that I last saw him alive on June 2, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chr Myocarditis	2 yrs
Due to Hypertension	2 yrs
Due to Chr Glomerulo Nephritis	2 yr
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 Max Starkloff (M. D. or other) MD

Address 5-12 Dover Pl. Date signed 6/8/47

(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 Harry J. Schumacher

Licensed Embalmer No. 2679

P. O. Address 7514 S Broadway

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.