

3. No. 2
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5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 15 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22853**
Registrar's No. **1472**

Registration District No. **317**

Primary Registration District No. **3068**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Maplewood**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2119 Bredell
(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 **St. Louis** **96**
(c) City or town **Maplewood** **5**
(If outside city or town limits, write "RURAL")
(d) Street No. **2119 Bredell** **3**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Franz Schlosser**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **4th**
year **1947** hour _____ minute _____ M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Maria Schlosser**
6. (c) Age of husband or wife if alive **50** years
7. Birth date of deceased **March 1, 1898**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 6** 19**47** to **July 3** 19**47**
that I last saw h. alive on **July 3** 19**47**
and that death occurred on the date and hour stated above.

8. AGE: Years **49** Months **5** Days **3**
If less than one day _____ hr. _____ min.

Immediate cause of death **Cancer of Stomach** **1947**
Due to **Metastasis to Liver and Peritoneum**
Due to _____
Other conditions (Include pregnancy within 3 months of death) **46**

9. Birthplace **Germany** (City, town, or county) (State or foreign country)
Syrup-man

Major findings: **Carcinoma well advanced**
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business **Beverage Co.**
12. Name **Schlosser**
13. Birthplace **Germany** (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 **Maria Schlosser**
(b) Address **2119 Bredell**
17. (a) **Burial** (b) Date thereof **7/7/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation **Calvary Cemetery**
18. (a) Signature of funeral director **M. J. Croghan**

While at work? _____ (Specify type of place) (b) Means of injury **C**

(b) Address **7146 Manchester Ave.**
19. (a) **7-10-47** (b) **Edward J. Sharkey**
(Date received local Registrar) (Registrar's signature)

23. Signature **Leonty Selassen** (M. D. or other)
Address **1005 Big Bend** Date signed **7/6/47**

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

MOTHER FATHER

DR. PETERSON
1005 SIGBEND

JUL 18 1947

APR 28 1948

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 Elmo R. Sachwell

Licensed Embalmer No. 4077

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.