

S. No. 2
DM-5-43
v. 17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 3 1947

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

State File No. 36223
Registrar's No. 9782

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:
6044 Horton Pl.
(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 William Schieszer,
3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
alive..... years
7. Birth date of deceased Nov. 1, 1910
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
36 11 20 hr. min.

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

10. Usual occupation Book-keeper

11. Industry or business
MOTHER FATHER { 12. Name Mottia Schieszer
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Woodsmall
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sarah Schieszer
(b) Address 6044 Horton Pl.
17. (a) Removal (b) Date thereof Oct. 22/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Marshall, Mo.

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiament Ave.
19. (a) Oct 22 1947 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County oac
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5 6044 Horton Pl.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 21
year 1947 hour 12.30 minute A.M.
21. I hereby certify that I attended the deceased from
July 17 - 1947 to Oct. 20 1947
that I last saw h... in alive on Oct. 20 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Valus Pneumonia
Due to.....
Due to.....
Other conditions asto arthritis
(Include pregnancy within 3 months of death)

Major findings: non
Of operations.....
Of autopsy no
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? Non
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? Non (Specify type of place) (By means of injury)
23. Signature James D. Kelly (M. D. or other)
Address 10/21/47 Date signed Oct 22 1947

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

Dr. P. J. Rilly
6125 Bartmer Ave.,
CA. 5887-5187.

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.....

Alfred J. Bredeker

Licensed Embalmer No.

2663

P. O. Address..... *1125 Hodiament Ave.,*

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.