

FILED NOV 3 1947

318

1003

Registration District No. **318** Primary Registration District No. **1003**

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

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:
4636A Steinlage Drive
(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)

3. (a) PRINT FULL NAME **Barnard H. Soeker**
 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 **Widower**
 6. (b) Name of husband or wife **May Soeker** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Oct. 20, 1867**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	79	11	26	hr. _____ min.

9. Birthplace **Wright City, Mo.**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Retired Salesman**

11. Industry or business _____
 12. Name **Wm. Soeker**
 13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert Schmalmaack**
 (b) Address **6310A Sutherland Ave.**
 17. (a) **Burial** (b) Date thereof **Oct. 18, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Cemetery**
 18. (a) Signature of funeral director **Paschedag-Henke**
 (b) Address **2825 N. Grand Blvd**

19. (a) **OCT 17 1947** (b) **J. F. Probst**
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **000**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **4636A Steinlage Drive**
(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 **16th**
 year **1947** hour **7** minute **A** M.
 21. I hereby certify that I attended the deceased from **June 17, 1947** to **Oct 17, 1947**
 that I last saw him alive on **Sept 19, 1947**
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic myocarditis
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
93

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) **no**
 (b) Date of occurrence _____
 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? **no**

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

23. Signature **D. A. Phomson** (M. D. or other) _____
 Address **3121 N Grand** Date signed **10-17**

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.....

J. Allen Davis
.....
Licensed Embalmer No. *4053*

P. O. Address.....

St. Louis, 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.