S. No. 2
M—1/47
. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40142

FILED NOV 28 1947

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10558

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

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: Deaconess Hosp 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week (Specify whether
In this community Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 6243 Magnolia Ave. 9
(If rural, give location)

3 —

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Anna Scheuermann

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Frank G. Scheuermann

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased August (Month) 11 (Day) 1887 (Year)

8. AGE: Years 60 Months 3 Days 5 If less than one day hr. min.

9. Birthplace Clayton (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business Own home

FATHER
12. Name William H. Klatt
13. Birthplace St. Louis (City, town, or county) Mo (State or foreign country) 0

MOTHER
14. Maiden name Margaret Vasel
15. Birthplace Clayton (City, town, or county) Mo (State or foreign country) 0

16. (a) Informant Frank G. Scheuermann
(b) Address 6243 Magnolia Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Park Lawn Cemetery

18. (a) Signature of funeral director C. Hoffmeister Colonial Mortuary
(b) Address 6464 Chippewa St.,

19. (a) NOV 17 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16
year 1947 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct 1st 1947 to Nov 16 19
that I last saw her alive on Nov 16 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Hack Liver

Due to ?

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations Cholecystitis x Cholecystitis

Of autopsy Hack Liver

Duration

PHYSICIAN

Underline the cause of 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) 0

While at work? (e) Means of injury

23. Signature P.B. Cappel (M. D. or other) MD

Address 3284 Ivanhoe Date signed 11-17-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

P.B.Cappel

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 Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 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.