#87260

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 24 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31416

Registration District No. 318 — Primary Registration District No. — Registrar's No. 7883

1003

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1mo (Specify whether years, months or days)
In this community 30years 0

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

3. (a) PRINT FULL NAME ANTON SCHOCH
3. (b) If veteran, name war ---
3. (c) Social Security No. ---
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 Unknown (Month) (Day) (Year)
8. AGE: Years abt - 80 | Months | Days | If less than one day hr. min.
9. Birthplace Unknown (City, town, or county) (State or foreign country)
10. Usual occupation Nil
11. Industry or business
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
(MOTHER FATHER)
16. (a) Informant M. Renard
(b) Address St. Louis City Hospital
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-8-48 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY
18. (a) Signature of funeral director Cullen-Kelly
(b) Address 4386 Lindell
19. (a) SEP 8 1948 (Date received local registrar) (b) J. F. Bussick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 20th year 1948 hour 5 minute 10 A M.
21. I hereby certify that I attended the deceased from 7/20/48, 19..., to August 20th, 1948 that I last saw him alive on August 20th, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Recto-Vesical fistula and uremia — Duration
Due to
Due to
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 1515 Lafayette (M.D. or other) 8/20/48
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

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.....Ralph M Henson

Licensed Embalmer No.....3791

P. O. Address.....St. Louis M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.