

No. 300
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 13 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34671**
Registrar's No. **8727**

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: 2133 Nebraska
(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 Sadie Schoen
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced, Widowed
(b) Name of husband or wife John Schoen 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 1, 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 9 5 hr. min.

9. Birthplace Waterloo Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____
12. Name Ben Lofinck
13. Birthplace Germany
14. Maiden name V. Elizabeth Henckler
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Catherine Kells
(b) Address 2133 Nebraska Ave.

17. (a) Burial (b) Date thereof 10-8-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Weick Bro. Und. Co.
(b) Address 2201 S. Grand Bl.

19. (a) OCT 7 1948 (b) J. B. Sasser
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2133 Nebraska (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 6
year 1948 hour 10 minute 30 A. M.
21. I hereby certify that I attended the deceased from June 28
1948, to 10-6, 1948;
that I last saw her alive on 9-16, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Complete heart block & cardiac arrest Duration 3 yrs.
Due to Chronic myocarditis 1 yr.
Due to Benignity
Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury 0
23. Signature Edw. H. Edde (M. D. or other) M.D.
Address 4971 Chippewa Date signed 10-7-48

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 *James R. Duvall*.....

Licensed Embalmer No. *4526*.....

P. O. Address. *2201 S Grand*.....

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.