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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 31 1948

Registration District No. 2 7

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

42114

State File No.

Registrar's No. 9766

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Near Overland Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Near Overland, Mo. in St. Louis County
(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)

In this community: 30 years

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.: 4847a Labadie Ave.
(If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: Walter C. Schmidt

3. (b) If veteran, name war: ------

3. (c) Social Security No.: 489-07-5529

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Angeline Mueller Schmidt

6. (c) Age of husband or wife if alive: 32 years

7. Birth date of deceased: April (Month) 28 (Day) 1909 (Year)

8. AGE: Years 39 | Months 7 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace: St. Louis County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Buyer

11. Industry or business: Shoe Mfg.

FATHER
12. Name: John W. Schmidt
13. Birthplace: Pevely (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name: Emilie Maack
15. Birthplace: St. Louis County (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Mrs. Angeline Mueller Schmidt

(b) Address: 4847a Labadie Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 1, 1948 (Month) (Day) (Year)

(c) Place: burial or cremation: Laural Hill Gardens

18. (a) Signature of funeral director: Beiderwieden F. Home Inc.

(b) Address: 1936 St. Louis Ave.

19. (a) 12-1-48 (Date received local registrar) (b) Thurwood Lininger M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 28 year 1948 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from DIED WITHOUT MEDICAL ATTENDANCE, 19__; that I last saw him alive on ____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cause unknown	
Due to: 200C	
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: Thurwood Lininger M.D. (Coroner)

Address: Acting Commr. of Health Date signed: 11-30-48

(Licensed Embalmer's Statement on Reverse Side)

MAR 30 1955

JUL 28 1955

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 Max L. Weinfel

Licensed Embalmer No. 4170

P. O. Address 1936 St. Louis 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.