

No. 300
10. 48

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3616**

Registrar's No. **206**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076**

96

0

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

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jennings		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jennings	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 4100 Jennings	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4100 Jennings Rd			

3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth b. (Middle) Schrader c. (Last) Schrader			4. DATE OF DEATH (Month) (Day) (Year) January 26 1949		
--	--	--	--	--	--

5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH November 12 1860		9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis Mo				12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME Samuel Bartmann			13b. MOTHER'S MAIDEN NAME Catherine Golden			14. NAME OF HUSBAND OR WIFE Late Wm Schrader		
---	--	--	---	--	--	---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME Charles Meier		ADDRESS 3825 Melba Bldg PI	
---	--	------------------------------------	--	--	--	-----------------------------------	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Chronic Myocarditis		DUE TO (b) Senility					
		ANTECEDENT CAUSES		DUE TO (c) 93d					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
		II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 47d						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
------------------------	--	---	--	--	--	--	--	--	--

21a. ACCIDENT SUICIDE HOME HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
---	--	--	--	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
--	--	--	--	----------------------------	--

22. I hereby certify that I attended the deceased from **November 19 1946** to **Jan. 25, 1949**, that I last saw the deceased alive on **Jan 23, 1949**, and that death occurred at **3:45 PM.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Albert Wall M.D.		23b. ADDRESS 5322 Helen Ave		23c. DATE SIGNED 1/27/49	
--	--	------------------------------------	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE January 29 1949		24c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co.	
---	--	----------------------------------	--	---	--	--	--

DATE REC'D BY LOCAL REG. 1-27-49		REGISTRAR'S SIGNATURE Harold G. Jennings MD		25. FUNERAL DIRECTOR'S SIGNATURE Calvin F Feutz		ADDRESS 4828 Nat Bridge Blvd	
---	--	--	--	--	--	-------------------------------------	--

9-10-24
3-4

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed

John A. Mlinar

Signed.....

Student Embalmer

Licensed Embalmer No. *4186*

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.