

FILED MAR 4 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6708

State File No. ....

1620

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis MO</u>	c. LENGTH OF STAY (in this place) <u>40 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, MO</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>8649 ANNE H A</u>		d. STREET ADDRESS (If rural, give location) <u>8649 ANNETTA</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u> b. (Middle) <u>C</u> c. (Last) <u>SCHONEBERG</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 17 1950</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>April 29, 1856</u>		9. AGE (In years last birthday) <u>93 yrs.</u> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work doing most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>BARBARA SCHONEBERG</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>AL. W. GERST. 8649 ANNETTA ST.</u>			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthemia, etc. It means the disease, injury, or complication which caused death.	<b>MEDICAL CERTIFICATION</b> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CEREBRAL HEMORRHAGE.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u>  <u>10 yrs.</u>
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19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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21a. ACCIDENT SUICIDE (Specify) <u>NONE.</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>331X</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	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 JUNE 1945, to Feb 17, 1950, that I last saw the deceased alive on Feb 17, 1950, and that death occurred at 9:10 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Al W Gerst</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>2114 E Grand</u>	23c. DATE SIGNED <u>2-17-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>FEB 20, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis MO</u>	
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DATE REC'D BY LOCAL HEALTH DEPT. <u>FEB 18 1950</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Street &amp; Carroll 4600 Natl. Bridge</u>		
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WRITE PLAINLY—USING 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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Benjamin*.....

Licensed Embalmer No. *366*.....

P. O. Address *Miss M*.....

**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.