

FILED JUL 26 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25255

State File No. ....

318

1003

Registrar's No. 6346

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6141 Virginia Ave.		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2019	
		d. STREET ADDRESS (If rural, give location) 6141 Virginia Ave.	

3. NAME OF DECEASED (Type or Print) Anna Schroeder			4. DATE OF DEATH (Month) (Day) (Year) July 15, 1951		
a. (First)		b. (Middle)	c. (Last)		

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, Widowed	8. DATE OF BIRTH Oct. 7, 1869	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 60 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Golfred Warmbrodt	13b. MOTHER'S MAIDEN NAME Unk Ossenfort	14. NAME OF HUSBAND OR WIFE Emil Schroeder
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fred Schroeder 6141 Virginia
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		5 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chv Myocarditis DUE TO (c) Arterio Sclerosis		?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pernicious Anemia			8 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION None	20. AUTO(PSY)? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE 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) St. Louis Mo. Mo.
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 April 19, 1943, to July 15, 1951, that I last saw the deceased alive on Aug 14, 1951, and that death occurred at 10a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Mary Staibloff MD	23b. ADDRESS 512 Duane	23c. DATE SIGNED 7/16/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-18-51	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem.	24d. LOCATION (City, town, or county) (State) Lemay, Mo. (Mo.)
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DATE REC'D BY LOCAL REG. JUL 17 1951	REGISTRAR'S SIGNATURE E. B. Lanster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Southern Funeral Home 6322 S. Grand Bly.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

6346

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

*David Van Fossen*

Licensed Embalmer No. 4242

P. O. Address 6322 So 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.