

FILED APR 21 1954

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

14074

318

REG. DIST. NO. PRIMARY REG. DIST. NO. 1002 Registrar's No. 2985

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| BIRTH NO. | | REG. DIST. NO. | | PRIMARY REG. DIST. NO. 1002 | | Registrar's 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, MISSOURI | | c. LENGTH OF STAY (in this place) | | c. CITY OR TOWN St. Louis | | d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSPITAL | | | | e. STREET ADDRESS (If rural, give location) 24 2303 Cherokee St. 24 | | | |
| 3. NAME OF DECEASED (Type or Print) JOHN | | a. (First) | | b. (Middle) LEO | | c. (Last) SCHRADER | |
| 4. DATE OF DEATH | | (Month) APRIL | | (Day) 1 | | (Year) 1954 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced | | 8. DATE OF BIRTH April, 3, 1892 | |
| 9. AGE (in years last birthday) 61 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocery Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Grocery Business | | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13a. FATHER'S NAME William Schrader | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE None | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 486-40-1567 | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wm. Schrader, 6344 Vita Dr. Affton, 23, Mo. | | | |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumococcal Pneumonia | | ANTECEDENT CAUSES | | | | | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | DUE TO (b) _____ | | | | | |
| | | DUE TO (c) _____ | | | | | |
| 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 | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 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) 490X | | | |
| 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 3-25-54, 19__, to 4-1-54, 19__, that I last saw the deceased alive on 4-1-54, 19__, and that death occurred at 4:25A m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) Richard S. Buchanan M.D. | | | | 23b. ADDRESS 1515 Lafayette Avenue | | 23c. DATE SIGNED 4-1-54 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE April, 3, 1954 | | 24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. | |
| DATE REC'D BY LOCAL REG. APR 2 1954 | | REGISTRAR'S SIGNATURE J. Earl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Witt Bros. L. & U. Co. 2929 S. Jefferson Av | | | |

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.....
Signature of Student Embalmer

Signed *J. M. Davis*.....

Licensed Embalmer No. *374*

P. O. Address *2929 So. Jeff*

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 embalmed by a **STUDENT**, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.