

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26314**
7023
Registrar's No.

FILED JUL 31 1952

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS		c. LENGTH OF STAY (in this place) 3 1/2 YRS.	c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		2069
d. FULL NAME OF HOSPITAL OR INSTITUTION 5349 MAFFITT			d. STREET ADDRESS (If rural, give location) 6 5349 MAFFITT		
3. NAME OF DECEASED (Type or Print) a. (First) AUGUSTA b. (Middle) AMELIA c. (Last) SCHROEDER			4. DATE OF DEATH (Month) (Day) (Year) JULY 22 1952		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 4 1864	9. AGE (In years last birthday) 88	10. UNDER 1 YEAR 1
				11. BIRTHPLACE (City and State or Foreign Country) OLIVE TOWNSHIP ILL.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME CONRAD DOERING		13b. MOTHER'S MAIDEN NAME SOPHIA EHLERS		14. NAME OF HUSBAND OR WIFE CHARLES SCHROEDER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Arthur H. Schroeder Jr.		
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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-vascular renal disease. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Ch. myocarditis + arteriosclerosis DUE TO (b) _____ DUE TO (c) _____				18. MEDICAL CERTIFICATION INTERNAL BETWEEN ONSET AND 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)	
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? 4221	
22. I hereby certify that I attended the deceased from 7/15/52 , to 7/22/52 , that I last saw the deceased alive on 7/22/52 , 19 52 , and that death occurred at 4:30 a.m. , from the causes and on the date stated above.					
23a. SIGNATURE W.F. Nelson M.D.			23b. ADDRESS 5203 Chippewa		23c. DATE SIGNED 7/22/52
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE JULY 24 1952	24c. NAME OF CEMETERY OR CREMATORY MT. OLIVE		24d. LOCATION (City, town, or county) (State) MT. OLIVE ILL.	
DATE REC'D BY LOCAL REG. JUL 22 1952	REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehman-Harral 1905 Union Blvd.		

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

Motor

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 Albert R. Thompson Jr.

Licensed Embalmer No. 4237

P. O. Address St. Louis

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.