

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

807
Do not use this space.

REC'D FEB 10 1939

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003**
 (c) City **St. Louis** (d) Street No. **4239 Delmar** St.
 (e) Length of residence in city or town where death occurred **50** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Miss SCHRADER (KATE) Kate Schrader
 (a) Residence, No. **4239 Delmar Ave** St. **19**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) **single**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 8th, 1852**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
86 8 16

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Seamstress**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Private families**
 10. Date deceased last worked at this occupation **December 1938** 11. Total time (years) spent in this occupation **50**

12. BIRTHPLACE (CITY OR TOWN) **Canton** (STATE OR COUNTRY) **Mo**

FATHER 13. NAME **Joseph Schrader**

14. BIRTHPLACE (CITY OR TOWN) **Unknown** (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME **Kate ?**

16. BIRTHPLACE (CITY OR TOWN) **Unknown** (STATE OR COUNTRY)

17. INFORMANT **Grace O. Severin** (ADDRESS) **3001 California**

18. BURIAL, CREMATION, OR REMOVAL PLACE **LaGrange Mo** DATE **Jan 27 39**

19. FUNERAL DIRECTOR (NAME) **Henry L. Weidemuller** (ADDRESS) **8203 Gravois Ave**

20. FILED **Jan 26 39** **J. Budick** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-24-1939**

22. I HEREBY CERTIFY, That I attended deceased from **1-18-1939** to **1-24-1939**

I last saw h. **ER** alive on **1-24-1939**. Death is said to have occurred on the date stated above, at **8:15a.m.**
 The principal cause of death and related causes of importance were as follows:

CHRONIC INTERSTITIAL NEPHRITIS
CHRONIC ENDOCARDITIS
 Date of onset **UNKNOWN**

Other contributory causes of importance:

Name of operation **none** Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **none** Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **no**
 If so, specify.....
 (Signed) **Arthur L. W. Lester, M.D.**
 (Address) **507 St. Nicholas Ave**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed J. G. Sullivan

Licensed Embalmer No. 1122

P. O. Address 4764 Wash Blvd

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, above space should be left blank.