

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REG'D SEP 20 1939

Registration District No. 101

Primary Registration District No. 101

Registrar's No. 1650

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton

(c) Name of hospital or institution:  
St. Louis County Hospital

(d) Length of stay: In hospital or institution 6 days

In this community 3 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Richmond Heights

(d) Street No. 7559 Dale Ave.

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Ferdinand Schnadt 530

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Clara Schnadt 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 18 1865

8. AGE: Years 73 Months 11 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace unknown Ill.

10. Usual occupation nil.

11. Industry or business \_\_\_\_\_

FATHER { 12. Name Ferdinand Schnadt

13. Birthplace unknown Ill. U.S.A.

MOTHER { 14. Maiden name Catherine Wolf

15. Birthplace unknown Alsace Lorraine

16. (a) Informant's own signature Ferdinand Schnadt

(b) Address 759 Dale Ave.

17. (a) burial (b) Date thereof 9/19/39

(c) Place: burial or cremation Park Lawn

18. (a) Signature of funeral director P. M. Muller

(b) Address 5165 Delmar

19. (a) SEP 18 1939 (b) G. R. Meyer

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16

year 1939 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from 9/10/39 to 9/16/39

that I last saw him alive on 9/16/39 and that death occurred on the date and hour stated above.

Immediate cause of death arterio-sclerotic heart disease

Duration 4 yrs.

Due to \_\_\_\_\_

Due to 95% 2

Other conditions Pulmonary congestion

(Include pregnancy within 3 months of death) 9-10-39

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature C. Curtis E. Sauer (M. D. or other) \_\_\_\_\_

Address St. Louis, Mo. Date signed \_\_\_\_\_

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**