

JAN 12 1940 791

10784

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County 1  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: CITY HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 weeks  
(Specify whether years, months or days) 20 years  
In this community 20 years

3. (a) PRINT FULL NAME

Cecelia Schmidt 5.30

3. (c) Social Security No. ✓

4. Sex FEMALE 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Paul Schmidt 6. (c) Age of husband or wife if alive 19 years

7. Birth date of deceased Feb 19 1862  
(Month) (Day) (Year)

8. AGE: Years 77 Months 9 Days 29 If less than one day hr. min.

9. Birthplace GERMANY  
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business None

12. Name Grace Arendt

13. Birthplace Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Eva Schmidt

(b) Address 9222 Ashland Overland Mo

17. (a) Burial (b) Date thereof Dec 20 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 3101r Cemetery

18. (a) Signature of funeral director Orthman Funeral Home

(b) Address 9222 Ashland Overland

19. (a) DEC 18 1939 (b) J. J. [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 1  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL") 6  
(d) Street No: 5746 A Theodosia  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 45 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 18th day Dec  
year 1939 hour 4 minute A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of Duration \_\_\_\_\_

Skull  
Fracture of Right Leg

Due to fall from second  
story window at her

Other conditions None  
(Specify pregnancy within 3 months of death)

Major findings: Of operation None 5746 Theodosia  
12/9/39 about 10.30

Of autopsy Accident

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 12/9/39

(c) Where did injury occur? St Louis Mo  
(City or town) (County) (State)

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

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

(e) Means of injury fall

23. Signature [Signature] (M. D. or other)

Address [Address] Date signed 1/8-39

**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. P. Dittmann* .....

Licensed Embalmer No. *3478* .....

P. O. Address.....

**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.**