

N. E.—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.

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

Registration District No. 784 Primary Registration District No. 200 State File No. \_\_\_\_\_  
 Registrar's No. 149

**1. PLACE OF DEATH:**  
 (a) County St. Louis **FILED JAN 24 1940**  
 (b) City or town Rural St. Ferdinand  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Halls Ferry Rd. & Mehl Ave. 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community \_\_\_\_\_  
 years, months or days (Specify whether)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County St. Louis  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Halls Ferry Rd. & Mehl Ave.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**3. (a) PRINT FULL NAME** Anna Schladerbach 436  
**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_  
**4. Sex** Female **5. Color or race** White **6. (a) Single, widowed, married, divorced** Widow  
**6. (b) Name of husband or wife** George Schladerbach **6. (c) Age of husband or wife if** \_\_\_\_\_ years  
**7. Birth date of deceased** March 30, 1875  
 (Month) (Day) (Year)  
**8. AGE:** Years 64 Months 9 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Jan day 20th year 1940 hour 2:00 minute \_\_\_\_\_ P. M.  
**21. I hereby certify that I attended the deceased from** Sept 2nd, 1939, to Jan 20th, 1940,  
 that I last saw her alive on Jan 19th, 1940,  
 and that death occurred on the date and hour stated above.

**Immediate cause of death** Carcinoma of L. breast metastasis to spine **Duration** 1 year 2 mos.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

**9. Birthplace** Black Jack Missouri  
 (City, town, or county) (State or foreign country)  
**10. Usual occupation** At home  
**11. Industry or business** \_\_\_\_\_  
**MOTHER FATHER** { **12. Name** Herman Klostermann  
**13. Birthplace** Germany  
 (City, town, or county) (State or foreign country)  
**14. Maiden name** Elizabeth Heister  
**15. Birthplace** Germany  
 (City, town, or county) (State or foreign country)

**Other conditions** \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
**Major findings:** \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN** \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

**16. (a) Informant's own signature** Ann Schladerbach  
**(b) Address** Black Jack, Mo  
**17. (a) Burial** Black Jack, Mo. **(b) Date thereof** Jan 23, 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** \_\_\_\_\_  
**18. (a) Signature of funeral director** Charles W. Ferguson  
**(b) Address** 4911 Washington Bl.  
**19. (a) JAN 22 1940** **(b) R. K. Meyer**  
 (Date received local registrar) (Registrar's signature)

**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)  
 (a) Means of injury \_\_\_\_\_  
**23. Signature** Geo. Hughes (M. D. or other) \_\_\_\_\_  
**Address** Ferguson, Mo **Date signed** 1/24/40

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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. *3793*

P. O. Address *St. Louis Mo*

**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.**