

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9366
2849
Registrar's No. _____

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution 12 hrs. 45 min.
In this community 12 hrs. 45 min.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")
(d) Street No. 1316a Sarsfield
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Baby Schaeffer

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years
7. Birth date of deceased March 16, 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 12 hr. 45 min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business Nil

MOTHER FATHER { 12. Name John Schaeffer
13. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Williams
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]
(b) Address City Hospital, #1

17. (a) Cremation (b) Date thereof 3/29/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Hospital

18. (a) Signature of funeral director [Signature]
(b) Address City Hospital

19. (a) MAR 27 1940 (b) [Signature]
(Date received local registrar) (Registered Embalmer)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16,
year 1940 hour 6:45 minute A. M.

21. I hereby certify that I attended the deceased from March 16, 1940 to March 16, 1940
that I last saw h. _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Duration _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 [Signature] (M. D. or other) 3/19/40
Address 1515 Lafayette Date signed _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 complete the above constitutes grounds for revocation of license.)

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