

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **20050**

Registration District No. **791** Primary Registration District No. **1003** Registrar's No. **4998**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town **St. Louis**
 (c) Name of hospital or institution:
4504 Arsenal St.
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
 (d) Street No. **4504 Arsenal St.**
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **John Adam Schreiner**
3. (b) If veteran, name war **No.** **3. (c) Social Security No.** **None**
4. Sex **Male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Widowed**
6. (b) Name of husband or wife **Carolina** **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased **Dec. 24 1849**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **6th**
 year **1940** hour **5** minute **19**
21. I hereby certify that I attended the deceased from **Sept. 1939** to **June 6th 1940**
 that I last saw him alive on **June 6th 1940**
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	90	5	12	hr. _____ min. _____

Immediate cause of death
Chronic myocarditis. 8 mo
Chronic nephritis 8 mo
with decompensation and acute non specific
Due to _____
Due to _____

9. Birthplace **Coburg Germany**

10. Usual occupation **None**

11. Industry or business _____
MOTHER FATHER
12. Name **Unknown**
13. Birthplace **Unknown**
14. Maiden name **Unknown**
15. Birthplace **Unknown**

Other conditions _____
Major findings: **131**
Of operations _____
Of autopsy _____

16. (a) Informant **Miss Lena Schreiner**
(b) Address **4504 Arsenal St.**

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

17. (a) Removal **(b) Date thereof** **6-8-40**

(c) Place: burial or cremation **Edwardsville, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Ave.**

While at work? _____ **(Specify type of place)** _____
(e) Means of injury _____
23. Signature **J. J. Michael** **(M. D. or other)** **M. D.**
Address **506 Olive** **Date signed** **7/40**

19. (a) JUN 1940 **(b) [Signature]**

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: *Albert G. Hopper*

Licensed Embalmer No. *2971*

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.