

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 9107  
Registrar's No. 2517

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Trisco Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 days  
In this community Trisco Hosp  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County W.B. 999  
(c) City or town Girard  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 2 years.

3. (a) PRINT FULL NAME CHARLES A SCHROEDER

3. (b) If veteran, name war Spanish American 3. (c) Social Security No. 702-03-7342

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

6. (b) Name of husband or wife Abbie Jones Schroeder 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased May 11, 1879  
(Month) (Day) (Year)

8. AGE: 61 Years 10 Months 9 Days  
If less than one day hr. min.

9. Birthplace 1 New York  
(City, town, or county) (State or foreign country)

10. Usual occupation Section Laborer

11. Industry or business Trisco R.R.

12. Name Edmond Schroeder

13. Birthplace Olga Ludeman / New York  
(City, town, or county) (State or foreign country)

14. Maiden name Olga Ludeman

15. Birthplace 1 New York  
(City, town, or county) (State or foreign country)

16. (a) Informant Abbie Schroeder

(b) Address Girard Kansas

17. (a) Removal (b) Date thereof 3/20/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Girard, Kansas

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address 6633 Clayton Rd.

19. (Date received local registrar) MAR 20 1941 (b) J. F. Bredbeck (Registrar's signature)

MOTHER FATHER

MAR 20 1941

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20  
year 1941 hour 2 minute 35 A.M.

21. I hereby certify that I attended the deceased from March 10, 1941, to March 20, 1941; that I last saw him alive on March 20, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Paralytic ileus post-operative  
Due to Herniorrhaphy - indirect inguinal (Rt.)  
Duration 8 days  
3-11-41

Other conditions (include pregnancy within 3 months of death)

Major findings: Rt indirect inguinal Hernia  
Of operations Chronic pachymeningitis & granulations on 4th & 5th vertebrae  
Of autopsy Chronic pachymeningitis & granulations on 4th & 5th vertebrae

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 W. J. Collee (M. D. or other) D  
Address 4960 Lejeune Date signed 3-20-41

Duration

PHYSICIAN

Underline the cause to which death should be charged etiologically.

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

MAR - 6 1945

**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. 1994

P. O. Address St. Louis.

**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.**