

No. 2  
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17-39  
X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

43085

State File No. \_\_\_\_\_

FILED JAN 20 1942

Registration District No. 784

Primary Registration District No. 117

Registrar's No. 49

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Webster Grove  
(If outside city or town limits, write "RURAL")  
(d) Street No. 659 Kirkham Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 7th  
year 1942 hour 12 minute 5 A.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Natural causes

Due to Chronic Myocarditis

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy yes

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

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) Men (b) Men (c) Men  
23. Signature Louis N. Chapman  
Address Kirkwood Mo. 1/7/42 Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME ALBERT L. SCHACHT.  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mamie Schacht. 6. (c) Age of husband or wife if alive 57 years  
7. Birth date of deceased March 4, 1876.  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 10 3 hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired.  
11. Industry or business Wagon Maker.

12. Name Albert Schacht.  
13. Birthplace St. Louis, Missouri.  
(City, town, or county) (State or foreign country)  
14. Maiden name Fredericka Sendwald.  
15. Birthplace St. Louis, Missouri.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mamie Schacht.  
(b) Address 659 Kirkham Ave.

17. (a) Burial (b) Date thereof 1-9-1942.  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Oak Grove Mausoleum.

18. (a) Signature of funeral director Harry J. Askemeyer.  
(b) Address 51 Vernon Ave.

19. (a) \_\_\_\_\_ (b) H. M. Gannon  
(Date received local registrar) (Registrar's signature) 13.6.

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

MOTHER FATHER

**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.....

*Leonard W. Keegan*

Licensed Embalmer No.....

*5678*

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, fact should be so stated above.**