

FILED MAR 10 1943

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2535 Hebert St. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **20 Years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St Louis Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **2535 Hebert St.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Margaret Schroer**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, widowed **2 divorced Widowed**

6. (b) Name of husband or wife **Bernard Schroer** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **10 11 1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 4 15 hr. min.

9. Birthplace **Florissant Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Henry Albers**

13. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret Cording.**

15. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **H.G. Schroer**

(b) Address **9406 Chester Ave.**

17. (a) **Burial** (b) Date thereof **3-1-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Jordhart & Jordhart**

(b) Address **2228 St Louis Ave**

19. (a) **FEB 26 1943** (b) **J. F. B. [Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **26**
year **43** hour **9** minute **A. M.**

21. I hereby certify that I attended the deceased from **9 AM**
1943 to **Feb 27 1943**
that I last saw him **alive on Feb 24 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombosis**

Due to **Arteriosclerosis**

Due to **Hypertension**

Due to **Ch. nephritis**

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 **A. B. [Signature]** (M. D. or other) **Dr. D**
Address **2342 St Louis Ave** Date signed **2/28/43**

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 *Marie A. Cashion*
Licensed Embalmer No. *3949*
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.