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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

ED NOV 18 1943

Registration District No. **318**

Primary Registration District No. **100**

Registrar's No. **9754**

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:
8572 Drury Lane /
(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)

3. (a) PRINT FULL NAME **Kathinka Schleier**

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

3. (c) Social Security No. **None**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **George R. Schleier**

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **May 7, 1868.**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	75	5	29hr.min.

9. Birthplace **Hartford, Connecticut**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business.....

12. Name **Adalbert Wunder**

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

14. Maiden name **Bertha Bading**

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

16. (a) Informant **Mr. Ernest Just**

(b) Address **8572 Drury Lane**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **Nov. 9, 1943.**
(Month) (Day) (Year)

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

18. (a) Signature of funeral director **Calvin F. Feutz Funeral Home**

(b) Address **4828 Natural Bridge Blvd.**

19. (a) **NOV 7 1943** (Date received local registrar)

J. F. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **8572 Drury Lane**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **6th**,
year **1943** hour **12:50** minute **A.** M.

21. I hereby certify that I attended the deceased from **Sept 30**, 19**43** to **Nov 6**, 19**43**
that I last saw **her** alive on **Nov 5**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **auricular fibrillation**

Due to **Hypertensive heart disease**

Due to.....

Other conditions **plemia**
(Include pregnancy within 3 months of death)

PHYSICIAN

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?

(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature **H. F. Bergman** (M. D. or other) **M.D.**

Address **3720 Washington** Date signed **11/21/43**

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..... *V. Morris*

Licensed Embalmer No. *3360*

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, fact should be so stated above.