

FILED APR 26 1944
 Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2745th Armand Pl. 1
 (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 Rosa Schmit
 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 widow
 6. (b) Name of husband or wife Michel Schmit 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Aug. 13 1856
 (Month) (Day) (Year)

8. AGE: Years 87 Months 8 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Germany IL
 (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____
 MOTHER FATHER { 12. Name Unkn. Binz
 13. Birthplace Germany IL
 (City, town, or county) (State or foreign country)
 14. Maiden name Unkn. Binz
 15. Birthplace IL
 (City, town, or county) (State or foreign country)

16. (a) Informant Emmie M. Wahlen
 (b) Address 2745th Armand Pl.
 17. (a) Cremation (b) Date thereof: 4-20-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation no Crematory
 18. (a) Signature of funeral director With Bro. Lohme
 (b) Address 2929 S. Jefferson Ar.
APR 19 1944 J. J. Brueck
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County 0003
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2745th Armand Pl. 1
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 17
 year 1944 hour 9 minute 15 A. M.
 21. I hereby certify that I attended the deceased from Jan
26 1944 to ap 17 1944
 that I last saw her alive on ap 17 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Ch. myocarditis
 Due to Senility
 Due to 93
 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 0
 23. Signature at S. Kyre (M. D. 0000)
 Address 1803 Bestway Date signed 4-18-44

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

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 Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2929 S. Jefferson Ave

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.