

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

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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. 14226

FILED JUN 25 1944
818

Primary Registration District No. 1003

Registrar's No. 5386

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:
5524 Oriole 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 40 Years.
years, months or days

3. (a) PRINT FULL NAME Katherine Scheer

3. (b) If veteran, name war None

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 Robert Scheer

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

7. Birth date of deceased Feb. 5. 1866
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	4	8	hr. _____ min.

9. Birthplace Waterloo Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Karl Weilbacher

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Sabila Mennert

15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Oscar C. Scher

(b) Address 5524 Oriole Ave.

17. (a) Burial (b) Date thereof 6/16/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter & Paul

18. (a) Signature of funeral director [Signature]

(b) Address 2117 E. Grand Blvd.

19. (a) JUN 14 1944 (b) J.F. Bredenk
(Date received local registrar) (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. 5524 Oriole Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13
year 1944 hour 6 minute 40 A.M.

21. I hereby certify that I attended the deceased from _____, 1940 to June 13, 1944
that I last saw he alive on June 10, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chor. Myocarditis

Due to arterio sclerosis

Due to _____

Other conditions (include pregnancy within 3 months of death) 9/2

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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)

Means of injury _____

23. Signature Matt Crowe (M. D. or other) M.D.

Address 6-13 44573 Pittsburg

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 Frank A. Moore

Licensed Embalmer No. 3041

P. O. Address 2117 E. Grand

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.