

FILED AUG 8 1944

Registration District No. **818**

Primary Registration District No. **1003**

Registrar's No. **6682**

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

**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:  
St. Johns Hospital  
(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** Louis E. Schanauer  
**3. (b) If veteran,** name war.....  
**3. (c) Social Security** 493-10-9043

**4. Sex** Male  
**5. Color or race** White  
**6. (a) Single, widowed, married,** Married  
divorced  
**6. (b) Name of husband or wife** Winnie Schanauer  
**6. (c) Age of husband or wife if** 49 years  
**7. Birth date of deceased** May 26 1886  
(Month) (Day) (Year)

**8. AGE:**  
 Years 58 Months 2 Days 5  
 If less than one day  
 hr. min.

**9. Birthplace** Madison Ind.  
(City, town, or county) (State or foreign country)

**10. Usual occupation** Car Operator

**11. Industry or business** Public Service

**12. Name** Unknown

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

**14. Maiden name** Unknown

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

**16. (a) Informant** Winnie Schanauer Schanauer  
**(b) Address** 5943 Wabada Ave.

**17. (a) Burial** Burial **(b) Date thereof** 8-2-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Hiram Cem.

**18. (a) Signature of funeral director** Drehmann-Harral  
**(b) Address** 1905 Union Blvd.

**19. (a)** JUL 31 1944 J. P. Bideak  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County 000  
 (c) City or town St. Louis 12  
(If outside city or town limits, write "RURAL") 96  
 (d) Street No. 5943 Wabada Ave  
(If rural, give location)  
 (e) Citizen of foreign country?.....  
(Yes or No)  
 If yes, name country..... 0

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month July day 31  
 year 1944 hour 12 minute 10 AM.

**21. I hereby certify that I attended the deceased from** 6-13-44, 19....., to 7-30-44, 19.....;  
 that I last saw him alive on 7-30-44, 19.....;  
 and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Cholecystitis calculous  
 Due to.....

Due to.....  
 Other conditions  
(Include pregnancy within 3 months of death)  
126

**PHYSICIAN**  
 Major findings:  
 Of operations Cholecystitis  
 Of autopsy.....  
 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)  
 (e) Means of injury.....

**23. Signature** R. H. Lyland (M. D. or other).....  
**Address** 3903 Park Date signed.....

**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.....

*Warren A. Carver*

Licensed Embalmer No.....

*3534*

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.**